Health System Diagnosis and Programing in Bosaso - Puntland State, Somalia

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List of Acronyms

BEmONC	Basic Emergency Obstetric and Newborn Care
CARMNA	Campaign on Accelerated Reduction of Maternal, Newborn and child mortality in Africa
CeMONC	Comprehensive Emergency Obstetric and Newborn Care
CMH	Commission on the Macroeconomics of Health
DFID	Department for International Development
DHIS2	District Health Information System 2
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunisation
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GBVIMS	Gender Based Violence Information Management System
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRT	Gruppo per le Relazioni Transculturali
HCs	Health Centres
HEART	Health &Education and Advice Team
HSCS	Health Systems Calculation Sheet
HSSD	Health Systems Strengthening Diagnosis
HSSP	Health Sector Strategic Plan
ICT	Information, Communication and Technology
IDIs	In-depth Interviews
ISDP	Integrated Services for Displaced Populations
ISDP	International Society for Developmental Psychobiology
JCU	John Carrol University
JHNP	Joint Health and Nutrition Programme
KIIs	Key Informant Interviews
LAW	Legal Action Worldwide

LMIS	Logistics Management and Information System
MCH	Maternal and Child Health Centres
MdM	Médicines du Monde
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NRHS	The National Reproductive Health Strategy
PHU	Primary Health Units
PLHIV	People Living With HIV
RDT	Rapid Diagnostic Tool
RH	Reproductive Health
SARA	Service Availability and Readiness Assessment
SCI	Save the Children International
SDGs	Sustainable Development Goals
SDS	Sharp Development Solutions
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHP	Sexual and Reproductive Health Project
STIs	Sexually Transmitted Infections
SWOT	Strengths Weaknesses Opportunities and Threats
ToR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNAIDs	United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VfM	Value for Money
WHO	World Health Organization
WV	World Vision

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0. EXECUTIVE SUMMARY

0.1 Summary Fact Sheet

Commissioning Agencies	Ministry of Health (Puntland), Medecins du Monde
Title of Assignment	Health Systems Diagnostics
Location	Bosaso District – Puntland state of the Republic of Somalia
Duration	60 days
Start date	July 25, 2016
End date	October 17, 2016

0.2 Summary of Scores

Leadership and Governance	42.5%
Essential Medicines	34.5%
Human Resources	40.7%
Health Information Systems	36.2%
Health Financing	25%
Service Delivery	27.5%

0.3 Summary of Methodology

The HSSD methodology was discussed and agreed beforehand with MdM, the MoH and a Steering Committee that had been constituted specifically for the assignment. A 5-step methodology was agreed as follows: preparation; literature review; collection of qualitative and quantitative data; a consensus building workshop, and; a programming workshop. A rigorous quality check process ensured that quality was assured throughout the process. The two workshops – the consensus workshop and the programming workshop – not only validated the findings and recommendations among the stakeholders but also ensured that the HSSD outcomes were largely in line with felt needs in the district's health sector. A highly

participatory process was employed for the programming workshop. This included a SWOT analysis and a scorecard exercise that prioritized the most important gaps in the system.

0.4 Summary of Key Findings and Recommendations

The Puntland health system is guided by an impressive number of regional-level policies, strategies and plans; among them, the Puntland Health Policy Framework, Puntland Health Act, the HSSP, Puntland Drug Policy, Hygiene and Sanitation Policy and Infant and Young Child Feeding Programme. The policy documents recognize the limited capacity of Puntland's institutions of public health administration and the weakness of the regulatory framework. Other challenges facing Puntland's health system include shortage of health facilities; weak HMIS leading to low quality and quantity of health data; underfinancing of the health sector; severe shortage of qualified health workers, and; inadequate supply of essential medicines.

The Ministry of Health manages and coordinates Puntland's health sector organization and infrastructure. The health system infrastructure includes a graduated system of facilities that offer pathways for referral. These are: Primary Health Units (PHU) at the peripheral level of the District Health System, Maternal and Child Health Centres (MCH), Health Centres (HC), Referral Health Centres/District Hospitals and Regional Hospital.

In accordance with the Terms of Reference, the assignment employed World Health Organization's (WHO) Six Building Blocks of Heath framework, i.e., Leadership and Governance; Service Delivery: Health Workforce; Health Information; Health Financing, and; Essential Medicines.

0.4.1 Leadership and Governance

Relationships between partners in the health sector are well established and there is an effective vertical coordination mechanism with good leveraging of resources. Inter-agency coordination is however weak indicating significant room for improvement in leveraging of capacities. A plethora of central and national level policies, strategies and plans indicate high-level leadership. Awareness of the guiding frameworks is weaker at lower levels indicating a potential disconnect between policy and practice. The health sector institutional structure is

weak but the government has made commendable attempts at improving overall efficiency through reforming the institutional structure. The capacity of the district team is weak compared to the regional team resulting in a blaring of roles between the two levels.

Recommendations:

- Increase awareness of policy at lower levels.
- Hold regular joint review meetings especially at the district level.
- Strengthen the district team's capacity, especially with infrastructure, staff capacity, and resource development and management.
- Enhance community involvement in health planning to increase uptake, ownership and longevity of health intervention, e.g., in family planning and FGM.

0.4.2 Service Delivery

Puntland's delivery of health services is well structured and the range of services available at each of the levels is well defined. Furthermore, a wide range of SRH services are offered in all facilities in the district with the support of MdM and other partners agencies. This service is however located around the urban areas. The community health education is not well coordinated and the uptake of modern family planning methods is quite slow. In as much as there is existence of guidelines, protocols and standards for service delivery, the facility Support Supervision Tool should be revised to monitor adherence to them. Moreover, the District MoH team needs capacity to be able to offer on-the-job technical support to the facilities. The private health sector is largely unregulated and the extent to which it complements the health provision in the district is yet to be documented. Still, emergency-oriented and humanitarian activities dominate the health sector, and the burden of large numbers of internally displaced persons remains an overwhelming task for the MoH and partner agencies.

Recommendations:

- Need to double-up on efforts to develop innovative health delivery models to reach rural communities.

- Routine monitoring efforts to check the adherence levels for all guidelines and protocols.
- Develop policy and administrative procedures to gather data from the private health facilities, and institute their regular quality assurance checks.

0.4.3 Health Workforce

Puntland has a health workforce policy but there are glaring gaps between policy and practice. There is a huge shortage of the health workforce and disparities in distribution between urban and rural areas. The staff demonstrate passion for service but remunerations levels are often too low and potentially demotivating. Moreover, incentives paid by partners are not standardized. Health training is unregulated and not well coordinated with needs. Major efforts are on-going to address skills gaps through on-the-job training, and both WHO and UNFPA are supporting courses in midwifery and other health sciences. Some cadres are missing completely from training menus of local institutions.

Recommendations:

- Support training institutions to standardize training and improve coordination between the institutions and MoH.
- Harmonize pay structure especially by partners to ensure MoH has control of workforce.
- Undertake HR audit to ensure systematic response to gaps in the workforce.

0.4.4 Information Systems

There is a clear data flow process in Bosaso District as data registers are available at the facilities and there is clarity of data collection timelines from the facility level to the regional and national levels. However, there abounds insufficient capacity, both human and equipment, in data management at the district level. There' s a critical need to create linkages of the facility based data, to administrative data and population based data. Because the current Excel-based system in rigid, the introduction of DHIS2 is expected to help institutionalize the analysis of data at the District level, consequently improving the application of health data in planning. The planned linkage to LMIS will in addition support evidence-based planning and allocation of resources. The current HMIS system is not designed to gather data that helps in determining the progress made in various Central and District level frameworks, and plans. The formulation

of a strategic plan would strengthen this function as there will be clarity of SOPs and measurement of performance indicators.

Recommendations:

- Integrate data from vertical programmes and demography into the HMIS system.
- Develop staff capacities and ICT infrastructure at the district level.
- Conduct regular district stakeholder meetings for data review and planning.

0.4.5 Health Finance

Puntland suffers chronic underfinancing of its health sector. Overall, however, health financing has increased by 180% between 2005 and 2015. The bulk of funding is provided by international donor agencies with the government contributing only $1 million, or 2% of the budget. There is no central financial reporting system, which in effect presents challenges to planning and accountability. Similarly there are no data on allocation to Bosaso district. There is also no district financial management system to allow for tracking of budget and expenditure. It is not clear what the various actors such as the private sector contribute to health financing, although a significant part of the population depends on them. There is also no data on contribution and allocation of health resources to various health functions. It is clear from the stated priorities of various programmes that financing for SRH is a major focus of the health system. Finally, there is no clear sustainability strategy despite the heavy reliance of donors.

Recommendations:

- Undertake a costing study of the main programmes to ensure that resources are distributed optimally.
- Establish a financial management system at the district to consolidate health budgets and expenditure outlook.

0.4.6 Access to Essential Medicines

Puntland's supply management system is predominantly supported by donors and is based on the Push System. This system often results in stock-outs and oversupply of medicines and equipment that are not appropriate or in use. However, at the District level, there are efforts to utilize the Pull System as frequent drug use reports are generated by the facilities. With the establishment of the LMIS, it is expected that medicine and pharmaceutical supply will greatly improve. The regional hospital and all the HCs have drug stores with proper shelves, proper inventory, and sufficient cold storage. In as much as the private pharmaceutical sector provides most of the medicine to the population, it is still an unregulated sector.

Recommendations:

- Expedite the establishment of the LMIS to perpetuate a needs-based system of supplies.
- Institute a Pharmaceutical Board within MoH for regulation of the private pharmaceutical sector.

0.5 Summary of Proposed Intervention

Elements	Indicator descriptions
Goal: *Strengthen the District Health System as a means of improving access and quality of essential health services, consequently increasing the surge capacity at the District level.*	% Improvement in benchmarking scores
	Presence of District level health care frameworks (by each building block)
Outcome 1: To strengthen data management to inform decisions planning and budgeting	Presence of comprehensive indicator list for all the cohorts
	# of data quality audits undertaken at all district health facilities
	% of HMIS information use in LMIS
	# of periodic review of HMIS tools for improvement
	# of health facilities with modern ICT infrastructure e.g. computers and printers
	# of capacity development activities undertaken on data generation and analysis
Outcome 2: Strengthened financial management system for enhanced efficiency and accountability	District financial management system in place
	Presence of a Framework for financial decentralization
	Presence of a Resource mobilization strategy
	Consolidation guideline of different resource streams in place

	Number of budgetary and planning review meetings
	Increase of total amount of resources at the district
	Presence of a District health committee
	Presence of a District finance department
	District procurement system in place**
Outcome 3: To improve the administrative and management function for effective accountability and coordination of the health system	% increase in the number of district demonstrating knowledge of respective policies, plans and guidelines
	District-level health management structure with defined roles and responsibilities in place
	% of evidence-based decision making in planning and budgeting at the district level
	Presence of a framework for horizontal, agency-to-agency coordination
	% improvement in workforce to population ratio (broken down by population)
Outcome 4: To enhance performance management and motivation of health Human Resource to meet the health system goals	# of staff given in-service training
	Presence of mechanisms to measure staff performance
	Presence of HR department at the district level
	Presence of procedures for standardization of staff salaries

1. INTRODUCTION

1.1 Purpose of the HSSD

The purpose of the Health Systems Strengthening Diagnosis (HSSD) is to identity gaps and strengths of the health system in Bosaso District of Bari Region in the Puntland State of Somalia with the aim of designing a programming strategy. The HSSD process would then yield two outcomes. The first is the diagnosis report serving as a baseline and highlighting strengths and weaknesses of the health system in Bosaso District. The second is a programming strategy serving as a blueprint for stakeholder interventions to strengthen the health system in the district.

1.2 Geopolitical Context

1.2.1 Somalia

Somalia has a population of approximately 12 million people distributed across three administrative regions of South Central, Somaliland and Puntland. Prolonged internal conflict in the country over two decades destroyed most legitimate institutions and created widespread vulnerabilities among the population. Local and international efforts to stabilize the country have yielded varying results. Whereas the South Central region has remained unstable, Somaliland and Puntland have enjoyed relative stability and have put in place functioning public institutions.

Overall, however, Somalia is developing positively. A federal government has been constituted and a national constitution is now in place. In Somaliland and Puntland, forms of governments that combine modern institutions with traditional authorities have given them broad local legitimacy, which has resulted in relative stability and enabled them to develop frameworks for providing basic services. In the South Central region, the federal government, with support of international community, is reclaiming more territory from extremist groups.

1.2.2 Puntland

Puntland declared autonomy in 1998 with the goal of delivering basic services, offering security as well as to facilitating trade and interactions with local and international partners. The Somalia federal constitution strengthened this mandate by giving the region formal autonomy in dealing with majority of its economic and social issues. Subsequently, one of the goals of the Puntland second 5-year development plan is to improve basic health, especially for mothers and children.

1.3 The Health Context

Conflict has nearly decimated Somalia health sector, with especially profound impact on the sector's human resources, infrastructure, management, service delivery and support system. This is critical considering that the system was already in disarray during most of the 1980s. By early 1990s, about 80% of the Somali population had no access to basic health care. Somalia was also reporting some of the worst health indicators in the world. Although the situation has improved significantly, key indicators still remain at or near the bottom of world ranking; for instance, maternal mortality rate of 850 per 100,000 in 2013; under-5 mortality rate of 145.6 per 1,000 live births; 38.4% of births attended by skilled personnel; 12.7% of deliveries conducted at health facilities, and; 2.6% contraceptive prevalence rate.[1] At least 98% of women aged 15 to 49 years have undergone FGM.[2] A large segment of the population is without access to basic health services and with complete absence of some higher-level services in many regions[3].

The Somali state remains too fractured and weak to finance a meaningful level of basic services to the population. The international community through the UN is currently providing the bulk of the funding to the health sector while actual delivery of services is dominated by NGOs[4] and the private sector without whom there would be no health care system to speak of[5]. For instance, total budgetary contribution to the health sector in the three regions in 2011 was miniscule $1.3 million - a paltry $1,000,000 and $300,000 for Somaliland and Puntland respectively[6]. However, notwithstanding the heavy dependency on external support, the sector has improved significantly in recent years. It was estimated that there were more health

[1] Puntland's Comprehensive Multi-year Plan for Immunization System, 2016 – 2020.
[2] UNICEF, MICS Puntland 2011
[3] Reproductive Health National Strategy & Action Plan 2010-2015, Somalia
[4] Puntland Second Five-Year Development Plan, 2014-2018, December 2013
[5] Ibid
[6] World Bank, 2011, a Decade of Aid to Health Sector in Somalia 2000-2009

facilities in Somalia in 2015 than during the period before the civil war[7] attesting to the heavy investments in the sector by the international community

The **Somali Health Sector** is guided by the federal constitution, the Health Sector Policy 2014 and regional Health Sector Strategy Plans, among other steering documents all of which underscore the importance of access to high quality health care services. Equally important is the need to improve health and nutrition education, environmental health, strengthen community-based interventions, and enhance community roles and ownership in the health system[8]. The Somali community health strategy calls for specific measures to reach nomadic populations and to strengthen self-care for selected health problems[9]. These policy frameworks are points of departure for Puntland's Health System. Puntland also implements the Essential Package of Health Services (EPHS) for Somalia under the Joint Health and Nutrition Programme (JHNP).

1.3.1 Sexual and Reproductive Health (SRH) situation in Somali

Living conditions for women and children in Somalia are some of the hardest in the world. Correspondingly, Somalia has colossal needs related to Sexual and Reproductive Health (SRH). There are huge gaps regarding Family Planning, Gender Based Violence (GBV), Female Genital Mutilation (FGM) and community health[10]. SRH is a major focus of the health system in Somalia and a special interest of MdM. This assessment focuses on SRH, including maternal health care and GBV, including FGM, in Bosaso district.

Sustainable Development Goal 3 on maternal health care seeks to *Ensure healthy lives and promote well-being for all at all ages.* The target is to reduce maternal mortality ratio worldwide to less than 70 per 100, 000 births. There has been a reduction of Maternal Mortality Rate (MMR) in Somalia by 40 percent, from 1210 in 1990 to 732 in 2015. The rate is however still unacceptably high[11]. Most maternal deaths arise from complications during childbirth that can be safely addressed through effective medical interventions. There is a critical link between improved maternal and reproductive health and overall improvement in the functioning of the

[7] Mid Term Review of the National Strategy and Action Plan 2010 - 2015
[8] WHO, 2014. Draft Somali Community Health Strategy
[9] WHO, 2014. Draft Somali Community Health Strategy
[10] MdM Proposal for Bosaso EMONC
[11] Summary Reproductive Health Status in Somalia

health system[12]. Strategic action planning for Reproductive Health is thus an issue of broader health system reform and development.

Female Genital Mutilation (FGM) remains near universal in Somalia. Although there is an increasing understanding of the link between FGM and risks such as complications at birth, fistula, HIV and pain during intercourse[13], prevalence has remained stubbornly high and there are no signs of significant change. The Federal Government has drafted a policy on FGM[14] and the fourth draft of the Sexual Offenses Bill has been prepared awaiting finalization and endorsement in 2016[15]. The Puntland Government in an effort to address the problem passed a law in 2011 banning the most extreme forms of FGM[16]. In addition, in 2013 Islamic scholars in Puntland issued a religious decree 'fatwa' banning FGM saying it had no basis in Islam[17].

Gender Based Violence (GBV) prevalence in Puntland is considered high. A total of 4,030 cases were reported during the period January to December 2015[18] with the highest prevalence reported in IDP settlements[19]. Of the reported cases between January and August 2015, 84.2% involved rape, physical assault and sexual assault. About 75% of the GBV survivors were IDPs and 93% were female[20]. This indicates that IDPs and women are particularly at risk from GBV. The government of Puntland has appointed a Task Force on GBV and the UN and partners have established referral pathways for basic psychosocial support and health services in some areas. However, coverage and quality are low and access to health services in rural areas in Somalia is limited[21].

HIV/AIDS situation in Somalia is difficult to assess[22]. However, slight zonal variations are noted with particular problems appearing in Port cities such as Bosaso. In Puntland, the epidemic is believed to be in concentrated pockets. National prevalence for those between the ages of 15-49 years is 0.55% while People Living With HIV (PLHIV) in Puntland were estimated at 0.59%[23]. UNAIDS' ANC surveillance report shows the mean HIV prevalence rates of ANC attendees to

[12] Reproductive Health National Strategy & Action Plan 2010-2015, Somalia
[13] Multi Indicators Cluster Survey, 2011
[14] Sheena Crowford and Sagal Ali: Situational Analysis of FGM/C Stakeholders and Interventions in Somalia
[15] UNDP (2015) 2015 Annual Report: Strengthening Gender Equality and Women's Empowerment in Somalia
[16] www.unicef.org/somalia/ reallives_14437.htm:*Regional Authority introduces an official policy to end FGM/C*
[17] Ibid
[18] Summary Reproductive Health Status in Somalia
[19] UNFPA GBV Information Management System (GBVIMS)
[20] UNFPA (2015) GBV Sub-Cluster Bulletin
[21] UNWOMEN Gender Programme, 2013
[22] Summary Reproductive Health Status in Somalia
[23] UNAIDS (2015) Progress report for Somali HIV and AIDS Response 2014

stand at 0.49% in Puntland[24]. Response to HIV and other Sexually Transmitted Infections (STIs) has not prioritized the most-at-risk populations and yet STIs prevalence among them is 7.8%. Whilst 57% and 71% of women and men respectively have ever heard about AIDS, knowledge of prevention of transmission through the use of condoms is low[25].

1.3.2 Puntland Health System

The Puntland health system is guided by an impressive number of regional-level policies, strategies and plans; among them, the Puntland Health Policy Framework, Puntland Health Act, the HSSP, Puntland Drug Policy, Hygiene and Sanitation Policy and Infant and Young Child Feeding Programme. Puntland also implements the EPHS and JHNP. The policy documents recognize the limited capacity of Puntland's institutions of public health administration and the weakness of the regulatory framework. Other challenges facing Puntland's health system include shortage of health facilities; weak HMIS leading to poor quality of health data; underfinancing of the health sector; severe shortage of qualified health workers, and; inadequate supply of essential medicines. – details of these challenges have been expounded further below in Section 3 of key findings.

MoH manages and coordinates Puntland's health sector organization and infrastructure. The health system infrastructure includes a graduated system of facilities that offer pathways for referral. These in Bosaso District comprise of: 5 Primary Health Units (PHU) at the peripheral level of the District Health System, 4 Health Centres (HC), 4 Maternal and Child Health Centres (MCH) also referred to as Referral Health Centres/District Hospitals and 1 Regional Hospital.

The main frameworks for financing, implementing and coordinating health interventions in Puntland and Somalia are the EPHS and JHNP. Designed in 2008, Somali EPHS provides a common framework and minimum standard to which the nascent health system can aspire. It has three levels of support – community engagement, service delivery and institutional support - which collectively seek to strengthen the health system amidst the huge challenges facing the country. The JHNP on it's part is a $236 million comprehensive multi-donor, multi-partner 5-year programme aimed at "improving maternal and child health and reducing mortality while strengthening the system that supports improved quality and access to health care"[26]. JHNP is

[24] Ibid
[25] Reproductive Health National Strategy & Action Plan 2010-2015, Somalia
[26] Somali JHNP, 2012 - 2016

coordinated by UNICEF, while implementation is undertaken through international and local partners with the leadership of MoH.

1.3.3 Focus on Bosaso and Role of MdM

The health infrastructure in Bosaso includes Bosaso General Hospital, 4 BeMONC Health Centres, 4 MCHs and 5 PHUs. MdM is the main partner to MoH in the district and is responsible for supporting all 8 HCs/MCHs. MdM works in partnership with the Integrated Services for Displaced Populations (ISDP), a local NGO, through the Sexual and Reproductive Health Project (SRHP)[27].

MdM provides medical supplies and equipment to all supported health facilities and manages the central drug store in Bosaso with the support of ISDP. The drug store holds medical supplies from UNICEF, UNFPA and MdM. In addition, MdM ensures referral pathways from health centres to Basic Emergency Obstetric and Newborn Care (BEmONC) centers. It also provides one ambulance to Bosaso general hospital[28].

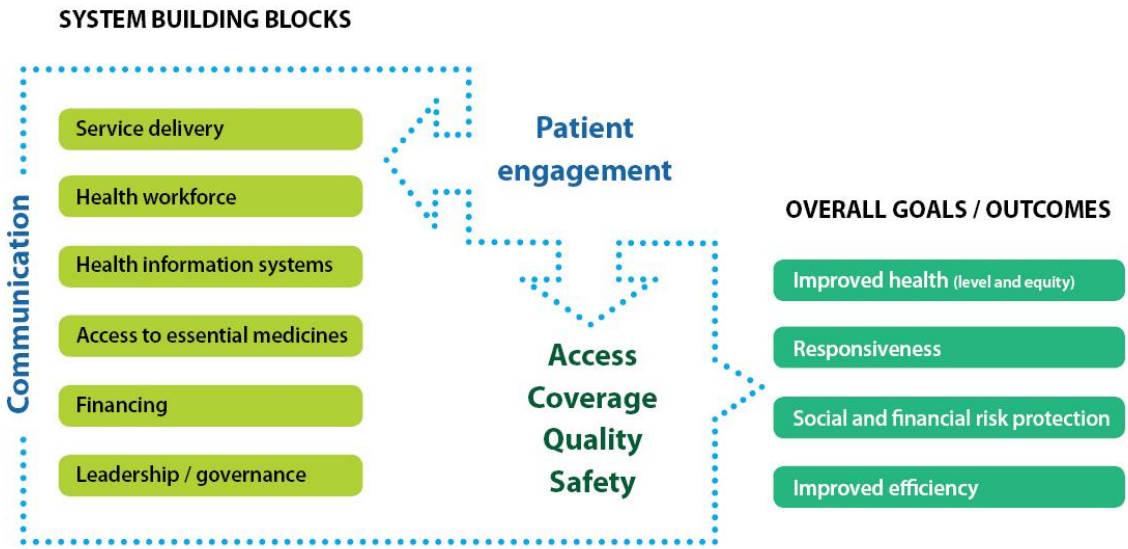
[27] Over over 50,000 IDPs
[28] MdM strategic plan

2. METHODOLOGY

2.1 The Approach

The HSDP involved a 5-step methodology guided by WHO's six (6) building blocks as shown in the illustration below;

Diagram: WHO's 6 Building Blocks



It employed a participatory approach steered by the Ministry of Heath with the active involvement of key health sector stakeholders in Puntland and specifically in Bosaso district. The 5-step methodology is outlined below.

The first step; was the preparation phase led by the Ministry of Health (MoH). This step resulted into the identification of the key stakeholders that would contribute to the process, the itemization of relevant documents for secondary data, and, the establishment of a Steering Committee to coordinate and facilitate the diagnosis process.

The second step; was literature review. The review provided an overview of the context as well as information on the health system and resulted in the formulation of an Explanatory Note/Inception Report. The Explanatory Note comprised the work schedule that would guide the HSSD process as well as all the tools to be administered in the course of the assignment.

The third step; included collection of both qualitative and quantitative data. This comprised administering KIIs, IDIs, FGDs, health center checklists and health user questionnaires to key health system stakeholders *inter alia* Puntland's Ministry of Health officials at the central, regional and district levels; Puntland's Ministry of Women Affairs, UN agencies like WHO, UNICEF, UNFPA; international NGOs such as MdM, SCI, GRT, World Vision; local NGOs such as Badbaado, ISDP, and; religious leaders, health workers, health training institutions, administrative leaders, women with children, youth and community health users.

The fourth step; was the consensus-building workshop. The Steering Committee facilitated the validation of the preliminary findings from the HSSD process by health multi-stakeholders.

The fifth step; was the programming workshop whereby health stakeholders participated in a SWOT analysis and scoring of the health system, benchmarking and prioritizing the interventions that formulated the programing strategy for the health system in Bosaso District.

2.2 The Chronology of Events

In summary, the following was the HSSD chronology of events;

Table: HSSD Work Schedule

PHASE	ACTIVITY	DESCRIPTION
Preparation ***(July 25 to August 3)***	Inception Meetings	• Introductory meetings with Puntland's MoH at the central level and MdM to set out the road map for the HSSD process.
	Steering Committee	• Establishment of an MoH-led Steering Committee in Bosaso District that coordinated and facilitated the HSSD process. • Establishment of an Advisory Committee

		convened by MdM-France to give oversight of the HSSD process.
Research ***(August 3 to September 10)***	Literature Review	• Desk review of secondary data from the MoH, UN agencies, international agencies and other relevant sources.
	Explanatory Note	• Development of an Explanatory Note detailing the conceptual framework, methodology, approach, time frame, tools and expected outcomes of the HSSD process.
	Field Data Collection	• Administering questionnaires to community health users and health facilities in Bosaso District. • Undertaking FGDs with mothers, women groups, youth groups, CHWs, TBAs, religious leaders and administrative leaders. • Conducting KIIs with MoH officials at the central, regional and district levels, and MdM staff. • Carried out IDIs with other government ministries like Ministry of Women Affairs; UN agencies like UNICEF, WHO, UNFPA; international agencies like Save the Children, CARE, World Vision, GRT; local NGOs like Baadbado and ISDP; health training institutions like Bosaso University.
Reporting ***(Sept. 19 to Sept. 27)***	Consensus-Building	• Bosaso Steering Committee led consensus-building of preliminary findings, conclusions and recommendations
	Programming Strategy	• Stakeholders jointly scored health system components and prioritized the health system interventions

3. KEY FINDINGS

3.1 Leadership and Governance

3.1.1 Partnership

The function of providing health services in Puntland is predominantly supported by non-state actors. The relationship between these actors and the Ministry of Health (MoH) is well established, and coordination within the health sector is well structured. At the Central government level, it is evident that bilateral donor agencies, UN agencies, and International Non-Governmental organizations (INGOs) like MdM, Save the Children, World Vision, GRT, CARE, etc., coordinate activities through periodic sector forums, and specialized working groups. The Joint Annual Planning Review process, led by WHO, is a good example of efforts to strengthen coordination at the central level. In Bosaso District, the Regional health management team works very closely with both local organizations such as Baadbado and ISDP, and INGOs to deliver essential health services. There is evidence of strong collaboration in the planning and execution of health programs and a desirable level of resource leveraging; like in the delivery of EPHS. The operations of partners in the district have been mapped either by geography or by type of service, and it's very clear what each partner does, and where they work. Coordination meetings are led by the MOH with the support of UN Agencies –which is a good indication of government ownership.

There would be value in increasing the frequency of the joint planning and review meetings, in improving direct agency-to-agency collaboration, and in ensuring that all partners (including training institutions) are adequately involved in the health sector planning and review processes. This would ensure coherence in the implementation of health interventions, create synergies between key actors and optimize the use of the resources available to the sector. It would also ensure that support provided by the agencies is harmonized and is responsive to the requirements of the system as a whole. A deliberate joint effort by the international agencies to build the capacity of MoH and sustain ownership should be a key agenda.

3.1.2 Policies, Plans and Frameworks

The Health Sector Strategic Plan (HSSP), the JHNP Rolling Plan and Annual Work Plans, the National Reproductive Health Strategy (NRHS) and Action Plan, Puntland Health Policy Framework, The HRH Policy, and the CARMMA Action Plan, are just a few of the key guiding documents for the health sector in Puntland - in which strategic objectives (with indicators and targets) are well described.

These documents have been endorsed by the central government of Puntland and are well understood by Ministry officials, and partner agencies at the central level. Apart from the NRHS, the plans and frameworks have not been reviewed and therefore the extent of implementation has not been adequately measured. There's little evidence of efforts to track the process of policy implementation; instead, a lot of monitoring and technical assistance efforts have been directed towards the specific programs like EPHS, EPI, etc. This scenario is reflective of practice both at the central level and at the district level. Even though most of these instruments have been developed with the support and guidance of UN Agencies or INGOs, it is evident that the commitment and ownership of the implementation processes by the Ministry of Health remains one of the guiding principles in ensuring the attainment of the set benchmarks.

Ownership and awareness of policy instruments is high at central level but decreases further down the government structure to the regional, district, facility and community levels. At lower levels, operations are guided more by practice and exigency than policy directives. It is important to create awareness of policies and strategies among the lower sections of government to ensure that everyone works toward the goals of the system. One way of doing this is to involve stakeholders at lower levels in policy development, implementation and review. While the MoH demonstrates commitment to implementing these instruments, the challenge of resources remains heavy. In addition, there are significant capacity gaps at the District level (both in the numbers and quality of staff), which continue to weigh down on several progressive efforts.

Out of the data gathered from health facility checklists, 84% of the staff interviewed had knowledge of the existence of the various policies, yet only 12% of these respondents felt the

policies were being implemented. Facilities had copies of the most essential operational guides and so it can be concluded that the policies and frameworks are adequate but a lot remains to be done to improve and track their implementation.

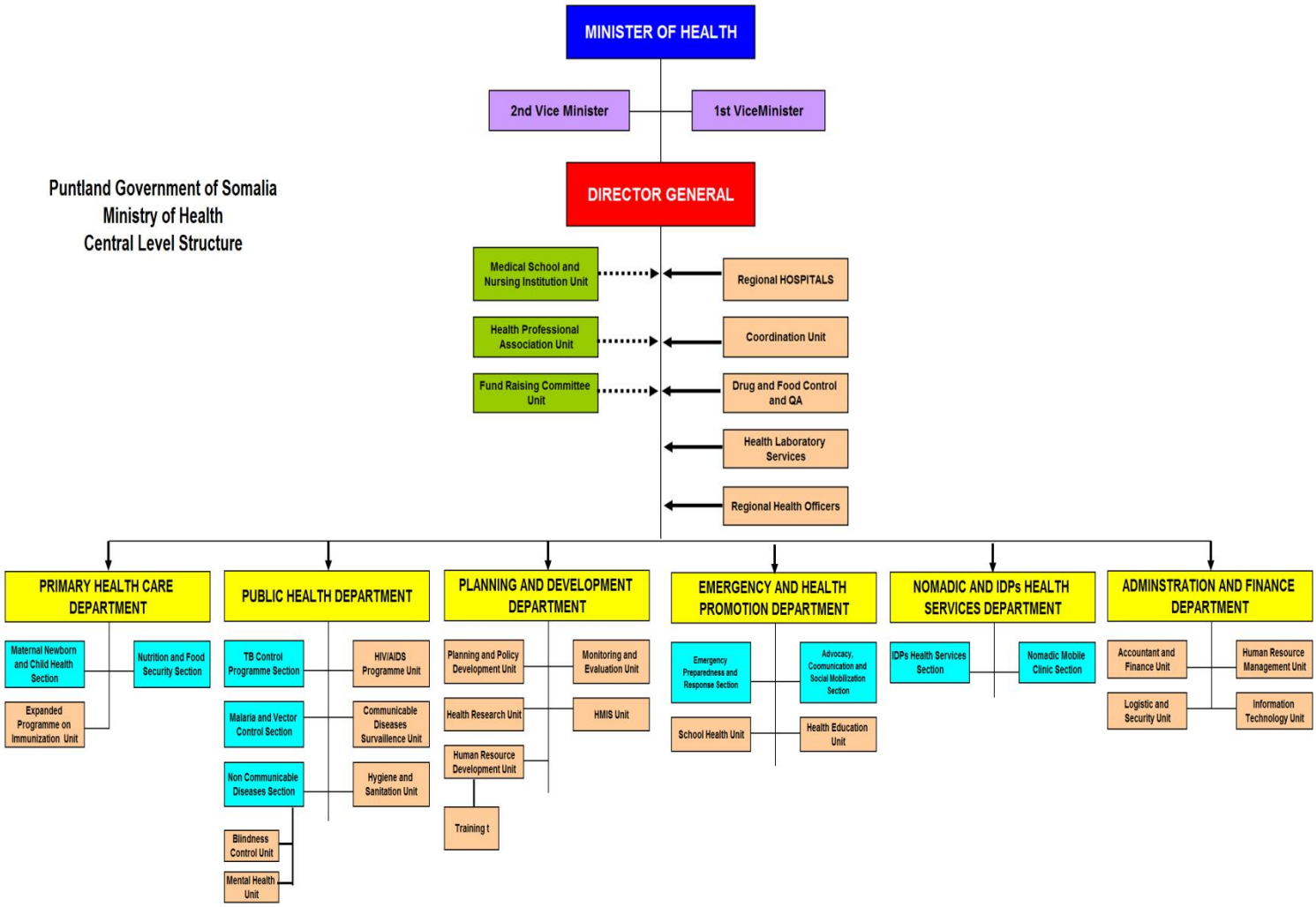
SRH is a top priority of the health system for which the government and health partners have demonstrated commitment through a number of facilitative policies, strategies and plans. An SRH policy defines the priorities while big components of the EPHS and JHNP are dedicated to SRH interventions. Moreover, the government has drafted two critical bills – the FGM bill and the Sexual Offences bill – that address these specific aspects of SRH.

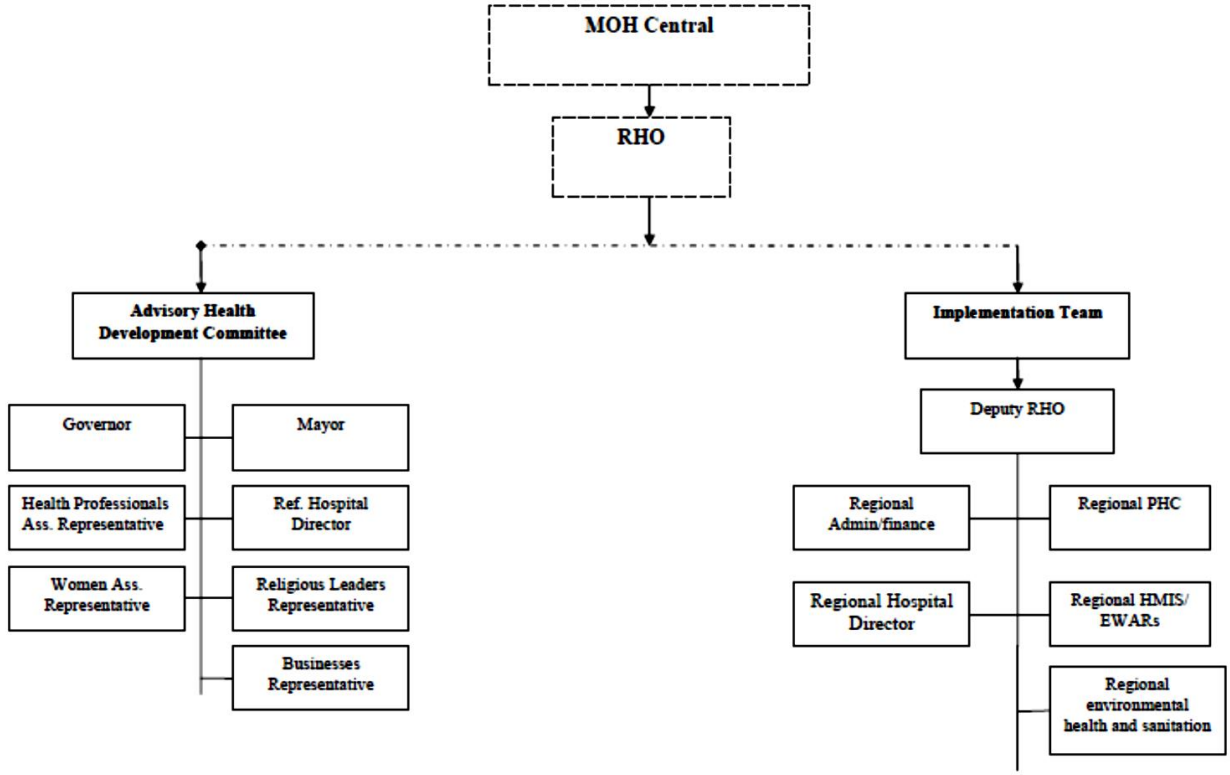
3.1.3 Institutional capacities

In Puntland, just like the other zones of Somalia, the organizational structure of the health ministry has been revised (in 2015), and the functions or terms of reference for the various departments and units have been reviewed. These Structures were revised to improve efficiency within the MoH and to institutionalize a structure that will finally take full operations of healthcare in Puntland. It should be noted that further to these structures, hospitals have their own operational structures, and there exists an operational framework at the District level, but it was difficult to obtain an endorsed document that clearly defines the structure of health management at the District level.

The diagrams below show the structures;

Puntland Government of Somalia
Ministry of Health
Central Level Structure





There are significant variances in the levels of operational and staff capacity between the regional team (Bari Region) and District team (Bosaso), and such differences in the levels of capacity have led to a close complementary working relationship between the regional and district MOH teams. In Bosaso District, there is minimal evidence of the involvement of the District team in Monitoring and Technical Assistance to the facilities, mainly due to the strong presence of the regional team, and very (pro)active involvement of INGOs. Support supervision is routine and feedback is often not shared with the facilities. There is little evidence of the utilization of data gathered during support supervision in planning and budgeting. While the complimenting role of regional team increases the capacity and resources available on the ground, it is necessary to fully empower the district team to play its role optimally. This will strengthen supervision and support to the facilities since the district team has that specific mandate and is closest to them.

3.2 Service Delivery

The delivery of health services is well structured and the range of services available at each of the levels is very well defined. The diagram below shows the various levels of health facilities and the range of services that are available.

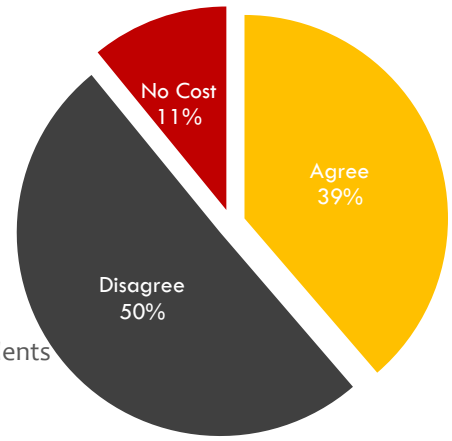
Primary Health Units	Health Centres	Referral Health Centres	Hospitals
The Primary Health Care Units (PHUs) operate at the most peripheral level of the district health system network and are staffed by Community Health Workers (CHWs). Each PHU is supported by a locally constituted Community Health Committee. The major role of the PHU is to provide basic promotive, preventive and simple curative services that include maternal, reproductive and neonatal health, child health, communicable disease surveillance and control, environmental health promotion, first aid and treatment of common illnesses. PHUs also promote nutrition education and the utilization vaccination services.	The Health Centre is assigned to deliver key programmatic interventions as envisaged in the Essential Package of Health Services (EPHS). The HC offers a facility based service with maternity beds operated by a qualified midwife. Each HC is also staffed by a qualified nurse, auxiliary nurse and a community midwife. HCs also provide facility based vaccination and nutrition promotion services, as well as outreach services to the HC catchment area. Community Health Committees are expected to provide support to the management of the HCs, and to assist the health teams in improving the uptake of health services provided, through sustained community mobilization.	The Referral Health Center supports the HC facilities with referrals, training and supervision. Most RHCs are not sufficiently equipped nor do they have adequate qualified health workers to attend to MNCH care and as well as other essential medical and surgical services. In addition to the six core functions set in the EPHS, RHCs carry out a range of medical and surgical services, and provide mental health care, treatment of chronic diseases, and dental and eye health. These facilities provide comprehensive emergency obstetric and newborn care (CeMONC), with the capacity to perform caesarean sections and reproductive health related surgical services. In addition to the Nurses and Midwives, RHCs are staffed by at least one Medical Doctor or clinical officer, an officer for the Expanded Programme on Immunization (EPI) and a laboratory technician. A Health Committee is established to provide the necessary support to improve hospital operations as well as to mobilize resources to fill the evolving operational gaps in these facilities.	The regional hospitals provide reasonable levels of specialist care, although the service demand overwhelmingly exceeds the capacity and the resources available. Regional hospitals provide medical, surgical, gynaecological and paediatric health care and other specialized services and are staffed by qualified nurses, midwives and doctors who are expected to conduct outreach clinics to RHCs. In Puntland, the management and coordination of this health system network is directly operated by the Ministry of Health, although the operational support for a tangible number of these facilities is profoundly assisted by international health partners whose contribution is highly valued. The regional EPI central cold chain and regional medical store are other key facilities instituted to support the health system network of the state. Bosaso General Hospital falls in this category.
EPHS COVERAGE: Six Core Programs	**EPHS COVERAGE: Six Core Programs**	**EPHS COVERAGE: All Programs**	**EPHS COVERAGE: All Programs**

Bosaso District has 5 Primary Health Units (also referred to as Health Posts), 4 Health Centers (commonly referred to as maternal and child health centres), 4 Referral Health Centres (sometimes known as District Hospital), and 1 Regional Hospital (Bosaso General Hospital). Most of the facilities do not provide the full range of primary and secondary or higher level care services identified in EPHS mostly due to challenges of staff capacity, health infrastructure and levels of financing.

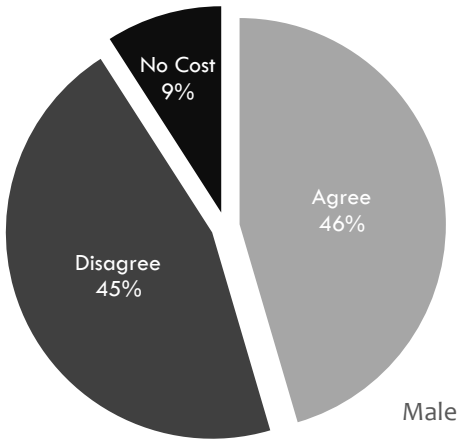
Service provision in all the health centers in the District is mainly supported by MdM (working with ISDP) for the EPHS program, and Save the Children for the Nutrition program predominantly in the PHUs and GRT for protection of IDPs. WHO, UNICEF, and UNFPA continue to provide essential technical support to the Regional and District Teams in order to track, and improve the range and quality of services provided. MDM recently expanded its coverage from 5 to all the Health Centres in Bosaso District.

All the services in the public facilities in Bosaso District is offered free of charge which means the only hindrance to accessing such facilities could be the cost of transport to the facilities. As indicated in the charts below, among female respondents 50% feel that the cost of transport to the facilities are not affordable, 39% feel the costs are affordable, while 11% of the respondents do not incur any costs to the facilities mostly because they live within close proximity to the facilities.

Chart: The cost of transport to the facility is affordable (Agree, Disagree, No direct cost involved)



Female Respondents

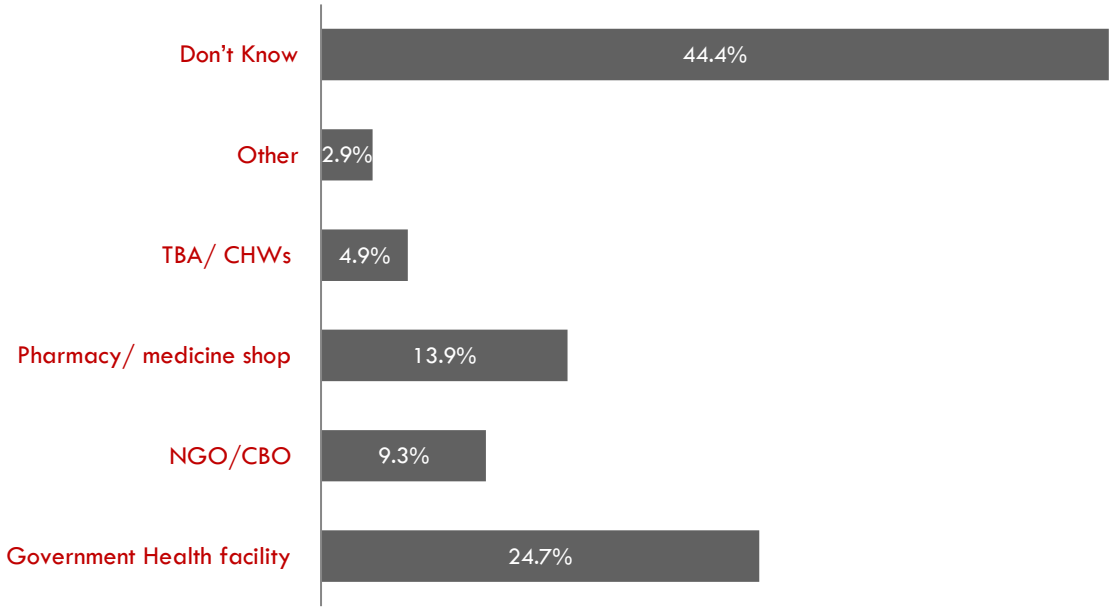


Male Respondents

However, when these findings are put within a geographical and social context, it is safe to conclude that the perceived high cost of transport has little to do with the sparsity of the facilities but instead has a lot of bearing on the levels of household income as an economic determinant of health.

Despite the concerted efforts to improve access to essential health services, especially RH services, it is evident that communities still do not receive regular health education. Community health education is understood to be the role of Community Health Workers, yet it is both unstructured and uncoordinated. Only 38% of respondents reported to have received some form of health information within the last month, and still a majority of the population do not have knowledge of where they can access birth control methods (as shown in the graph below);

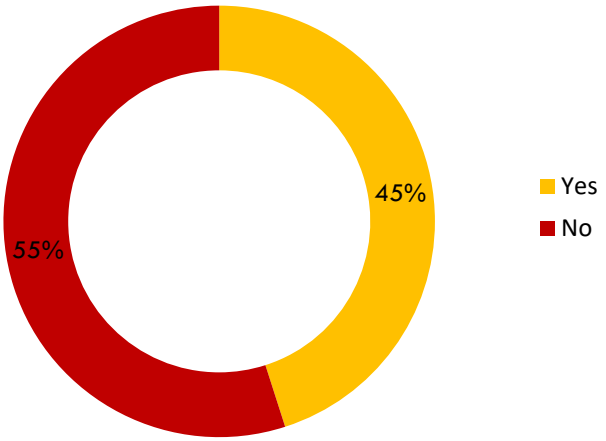
Graph: In this community, where can one get modern birth spacing methods?



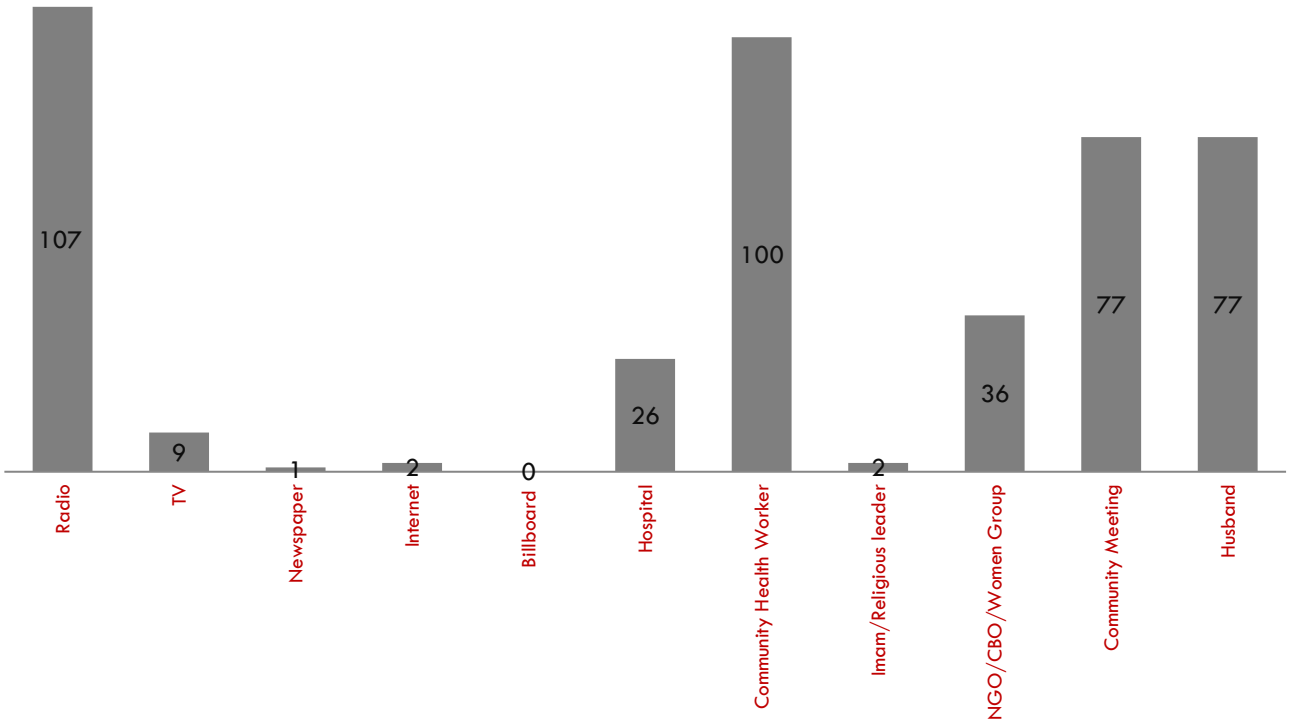
As an additional perspective, it is important to note that slightly more than half of the respondents (55%) indicated they had not heard nor read of any Reproductive Health information within the last 3 months. Of the female respondents that had received some health information, the main source was Radio, followed by Community Health Workers.

However, the study also established that husbands, and community/village meetings had a considerable influence on health information. This is information that would be useful in the efforts to improve community health education initiatives. The charts and graphs below are a depiction of access and source of health information.

Chart: In the last 3 months, have you heard or read information about reproductive health?



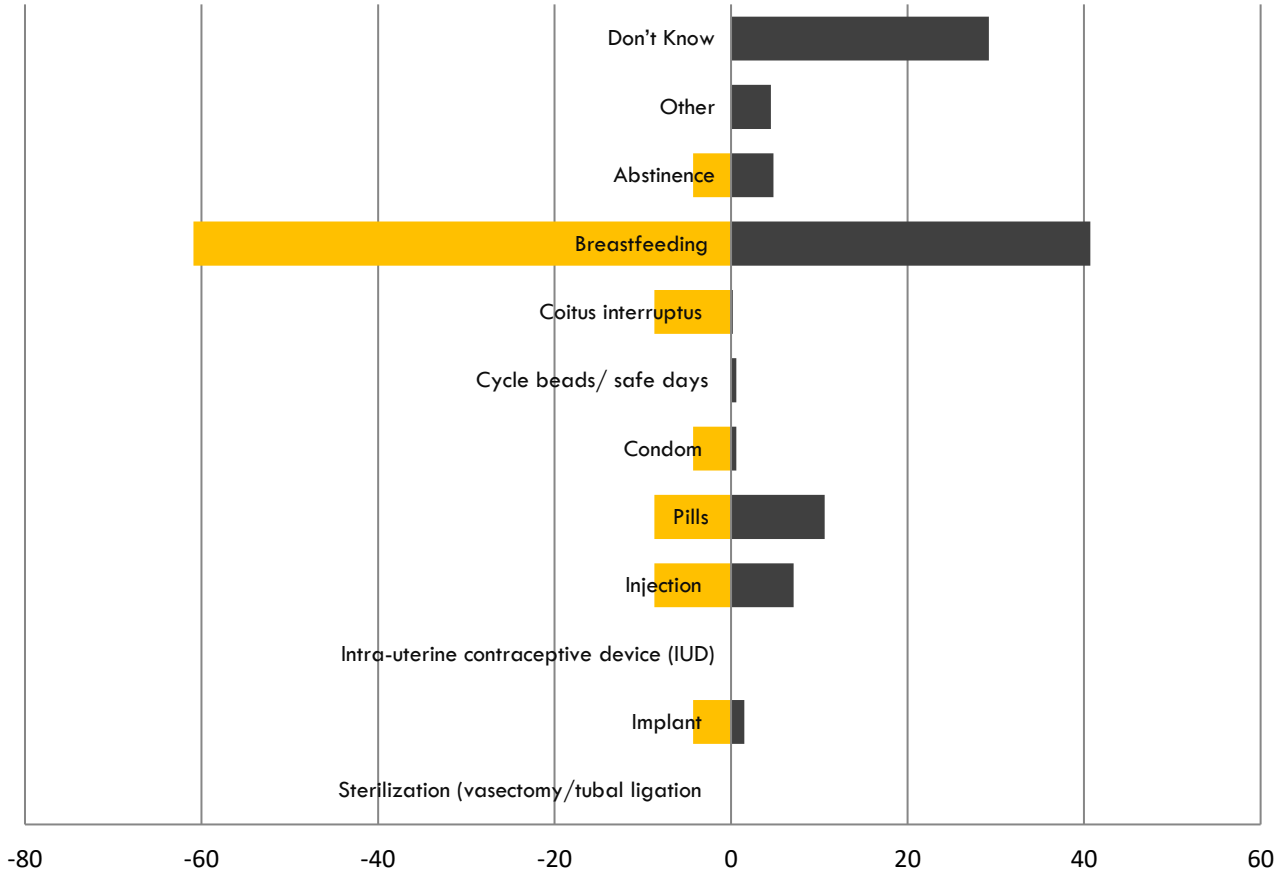
Graph: If yes, from what sources did you hear or read about reproductive health? *(Multiple response question, displayed in absolute counts, n=368)*



3.2.1 Reproductive Health Services

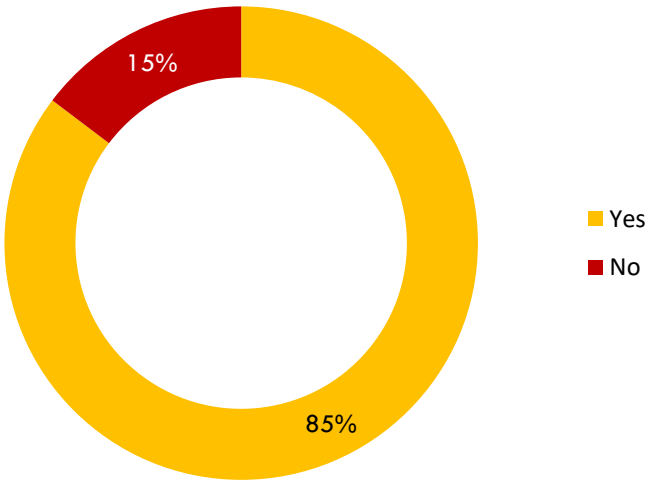
Health facilities in Bosaso provide a wide range of SRH services, including antenatal and postnatal care, family planning, GBV victims' support, and BeMONC and CeMONC services. According to various community representatives interviewed, the presence of 8 well-functioning health centres and referral health centres within Bosaso Municipality has greatly improved access to health care within the District. This efforts need to be intensified and sustained. Specific challenges remain with regard to family planning and FGM. Uptake of family planning services is still low with a majority of the population seeing modern family planning methods as against cultural and religious norms. The Graph below shows that Breastfeeding is the most known about method amongst men and women at 40.7% and 60.9% respectively.

Graph: In your knowledge, could you mention the methods that can be used to delay pregnancy and for healthy birth spacing?



FGM remains nearly universal despite the increased awareness of its effects on women and girls. Where change has happened it has been merely a shift from one form of mutilation to another – from infibulation to clitoridectomy. 85% of females interviewed had undergone FGM, and all of the respondents (both men and women) knew of someone who had undergone FGM.

Chart: Have you undergone FGM?



In summary; the gaps in Health Service Delivery in Bosaso District include;

- Minimal capacity of District Ministry of Health team to provide on-the job technical support to the facilities. There is an inadequacy of staff, and weaknesses in their depth of skill in the management of complex health programs.
- More resources are invested in central and regional levels than at the district level
- The concentration of EPHS within urban environments means that populations in rural environments face significant challenges in accessing BeMONC and CeMONC services. It is not evident if there are attempts, beyond the Health Posts, to make such services more available to these populations. This is therefore a compelling argument for the need to intensify rural/community level interventions.
- The private health sector is not well regulated and the extent to which they complement health provision in Bosaso District is yet to be documented. Information on their range of services, or quality of their staff is not available and no system in place to ensure such information is captured. There would be profound value in collecting data on the nature, utilization and quality of care provided by these private facilities.
- All the facilities have guidelines, protocols and standards but the extent of adherence to these instruments is (to a large extent) unmonitored. The MoH should consider revising the Health Centre/Health Post Support supervision tool to include the element of tracking adherence to protocols and guidelines.

- Still, emergency-oriented and humanitarian activities dominate the health sector, and the burden of large numbers of internally displaced persons remains an overwhelming task for the MoH and partner agencies.

3.3 Health Workforce

Puntland has a Human Resources for Health Policy covering the period between 2014 and 2018. It cannot be said that this policy document has been implemented, since there are still wide disparities between the path set out in the policy, and the situation of the Health Workforce. However, the presence of the policy itself is a commendable effort, as it appreciates the gaps in the workforce and describes (in sufficient detail) actions that need to be taken to improve the situation of the Health Workforce within the Zone.

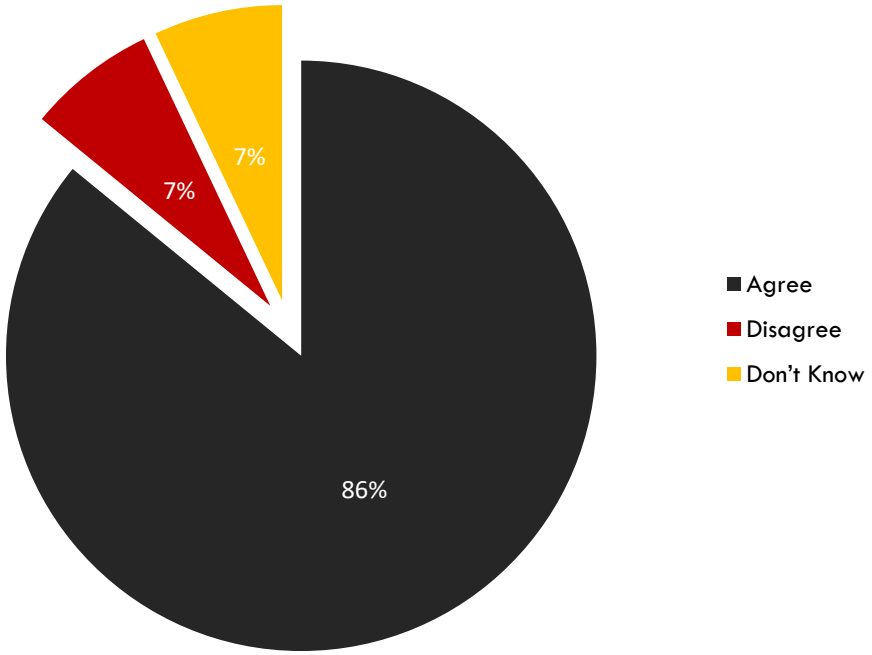
3.3.1 Training of Health Workers

Training is critical for effective implementation of essential health programmes, and for making a tangible progress towards the goal of Universal Health Coverage (UHC) and the attainment of the health focused SDGs.

In Puntland, and Bosaso District, the need to increase investment in the training of Health workers is overwhelming. As it is, there are commendable efforts by the NGOs and UN Agencies to provide on the job training to existing health workers, on the delivery of specific health services, or on specific support functions, such as HMIS. These trainings and workshops are critical and need to be sustained, but the general feeling amongst actors interviewed is that they remain inadequate in responding to the gaps in the workforce.

However, the existing workforce (as inadequate as they may be), demonstrate passion for their roles and are appropriately skilled to provide services. A majority of the female health users interviewed were of the opinion that the health workers at the Health Centers had the skills required to address their various needs;

Chart: What is your opinion about the following statements regarding giving birth at a health facility? - Health Workers Are adequately skilled?



Most health workers in the District are graduates of The East Africa University, the University of Health Sciences, or Bosaso College of Nursing since they are the main training institutions. These institutions are self-regulating with different course content, even though there are ongoing processes to harmonize the courses. In particular, WHO and UNFPA have been instrumental in supporting courses in Midwifery and Health Science disciplines.

Various reviews of the situation of workforce in Puntland have raised concerns around proper enforcement of certification, registration, accreditation and licensing of Health Professional Training Institutions – a concern which continues to be raised by health officials across the three levels (Central, Regional, District). This raises the question of the existence and functionality of regulatory frameworks for these institutions (public and private) and whether the MoH has the capacity to monitor and enforce such regulatory provisions.

Some of the observations generated from the assessment (that relate to the training of health workers) include;

- The non-structured relationship between the training institutions and the MoH is a hindrance to Workforce planning, as it creates a gap in the supply of the critically required workforce. Besides the training of Community Midwives, where the MOH and

UNFPA worked closely with the training institutions at the planning and implementation levels, it would be difficult to assert that the range and quality of trainings provided by the institutions are optimally responsive to the Human Resource gaps/needs of the health system.

- There is an inadequacy of teachers and lecturers and there are numerous instances where lecturers have had to be sourced from other countries. Based on the prevailing remuneration scales, it is evident that even in hiring foreign lecturers, they do not attract the best of skills.
- Throughout Puntland, it is difficult to find any existing training programmes for other key health workforce categories such as Clinical Officers, X-ray Technicians, and Anesthesia Technicians. This means that most (if not all) health workers in these fields have been trained in other countries – with an even higher likelihood that they are nationals of other countries. It would be useful for the MOH to consider making these courses available to locals through Public Private Partnership arrangements. It is not clear why local institutions are not producing these categories of workers.

3.3.2 Ratio and Distribution of Health Workers

Health workforce information is difficult to find, and updated data is not readily available. However, according to the information provided by the government health officials in Bari, the number and density of doctors, nurses and midwives is low throughout Bari region, and the entire Puntland Zone. The ratio of the number of health workers per population remains less than 4 per 10 000 population, which is far below the minimum threshold of 23 per 10 000 population defined as critical shortage. The two tables below is an indication of the distribution of health personnel across the public, private and non-profit sectors, and the gaps in the key workforce categories;

Table: Distribution of Health Personnel

Source: Puntland HRH Policy 2014-2018

Health Workforce Categories	Public		UN/NGOs		Private		Total
	M	F	M	F	M	F	
Doctors	37	10	8	3	43	9	**110**
Pharmacists	4	0	0	0	0	2	6

Health Workforce Categories	Public		UN/NGOs		Private		Total
	M	F	M	F	M	F	
Registered Nurses	204	287	0	0	63	110	664
Registered Midwives	0	230	0	0	0	51	281
Community Midwives	0	40	0	0	0	0	40
Auxiliary Midwives and Auxiliary Nurses	17	468	0	0	16	205	706
Anesthetic assistants	26	0	0	0	11	0	37
EPI officers	3	7	0	0	0	0	10
Lab assistants	30	13	0	0	46	13	102
Lab technicians	33	2	0	0	61	2	98
X-ray technicians	11	0	0	0	44	0	55
Pharmacist technicians	43	1	2	0	72	0	118
Dental technicians	7	0	0	0	34	0	41
Dentists Doctors	0	0	0	0	2	0	2
Ophthalmic technicians	2	0	2	0	5	0	9
Physiotherapists	3	0	0	0	1	0	4
Hospital administrators	17	0	7	0	20	0	44
Mental health technicians	7	0	0	0	1	0	8
Public Health Officers/Sanitarians	0	0	5	2	3	1	11
Clinical Officers	7	0	1	2	0	9	19
Community Health Workers	192	0	0	0	0	0	192
Ambulance Drivers	17	0	0	0	0	0	17
Cleaners	0	120	0	0	0	0	120
Guards	86	0	0	0	0	0	86
Grand Total	**751**	**1178**	**26**	**7**	**428**	**402**	**2792**

Table: Human Resources Gap

3 Key Workforce Categories	Currently Deployed in the health System	Cumulative coverage per 1000 population	Yearly production	Required workforce as per WHO Thresholds	HRH Gap as per WHO set minimum threshold
Doctors	110	4 doctors, nurses and midwives per 10,000population or (0.4 per 1,000 Population)	60	1242	1132
Registered Nurses	664		130	3312	2648
Registered Midwives& CMWs	321		70	1656	1335
Total	1095	0.4 per 1000population	260	6210	5115

There is an obvious disparity in the distribution of health workers between urban and rural environments. According to the Puntland HRH Policy, in 2014, 94% of Doctors, 93% of Nurses, and 67% of Midwives worked in urban environments. At the time of the diagnosis, there was not enough evidence to conclude that this situation has changed.

Information on the workforce is rarely gathered, yet such need to be constantly updated considering how significant it is to workforce planning and management.

The table below shows the exact number of health workers in different categories. These figures have been obtained from officials of the Ministry of Health in Bosaso District. Given a population estimate of 250,000 this works to about 6 health workers per 10,000 people - way below the WHO recommended ratio of 23 health workers for every 10,000 people.

Table: Health Workforce By Category in Bosaso

Workforce Categories	HC/MCH (8 facilities)	RHC (0 facilities)	Bosaso Hospital	Total
Aux Nurses	37	0	5	42
Registered Midwives	23	0	8	31
Nurses (Nut & EPI)	23	0	32	55
Lab staff	1	0	5	6
Clinical Officers	0	0	0	0
Doctors	0	0	12	25
Total	**78**	**0**	**62**	**159**

3.3.3 Remuneration and Motivation

There are no specific strategies or incentives to attract and deploy health workers. Salaries paid by the government are low (50USD), and often released after long delays. Additional stipends are provided by various donors based on their programs. This has led to wide disparities in the earnings of health workers (sometimes even within the same facility). Evidently, it can be deduced that given the Ministry barely has the capacity to pay its staff, and are reliant on external funding, there level authority to making strategic decisions is compromised. Equally compromised is the government's capacity to take full ownership of the health sector. The poor remuneration and the disjointed donor response have further profound implications on the sector. There is no standard approach to implementing the HR Strategy, making overall planning difficult at best. Without other forms of incentives, staffs are demoralized to the detriment of outcomes.

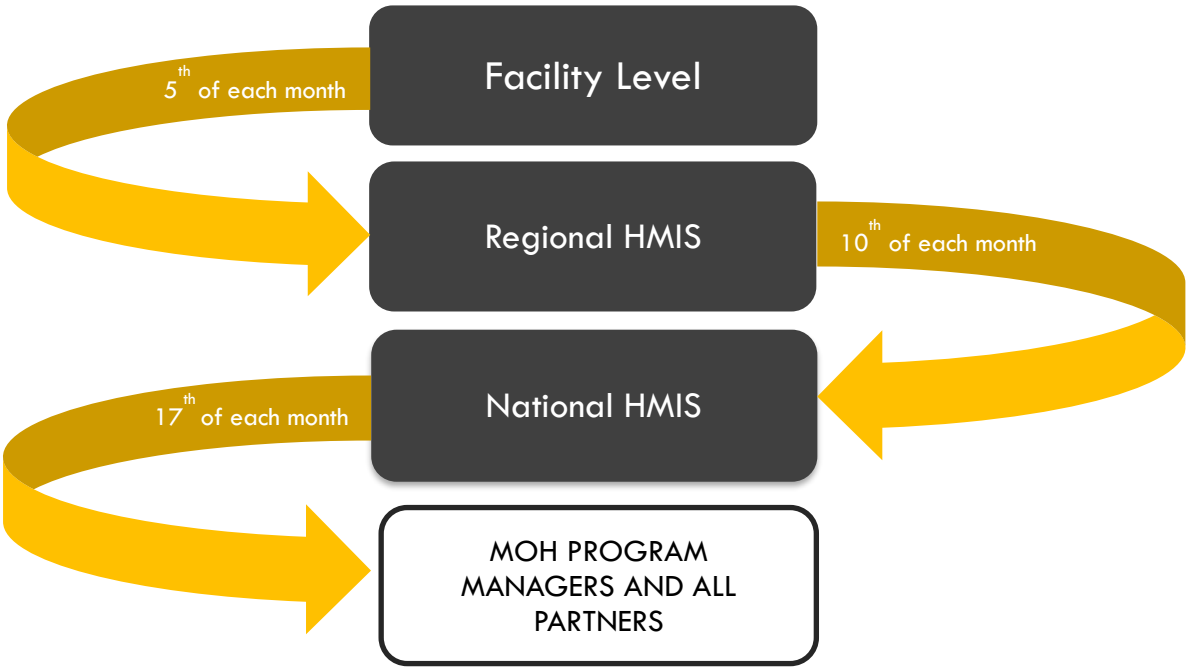
3.4 Health Information Systems

This is one of the most progressive components of the health system across all the levels (Central, Regional and District). Puntland HMIS system starts at the facility level. This data is compiled once a month and loaded onto HMIS database by regional HMIS officers before it's aggregated and analyzed by HMIS Unit manager. This is a well-defined process of data collection, analysis and review, and all the players are conscious of the structural and operational gaps there in - and demonstrate commitment to address these gaps. Data

registers are available at the facilities, there is clarity of timelines, and raw data from the facilities is often checked for completeness.

Diagram below is an indication of the data flow and the set timelines;

Diagram: Data Flow

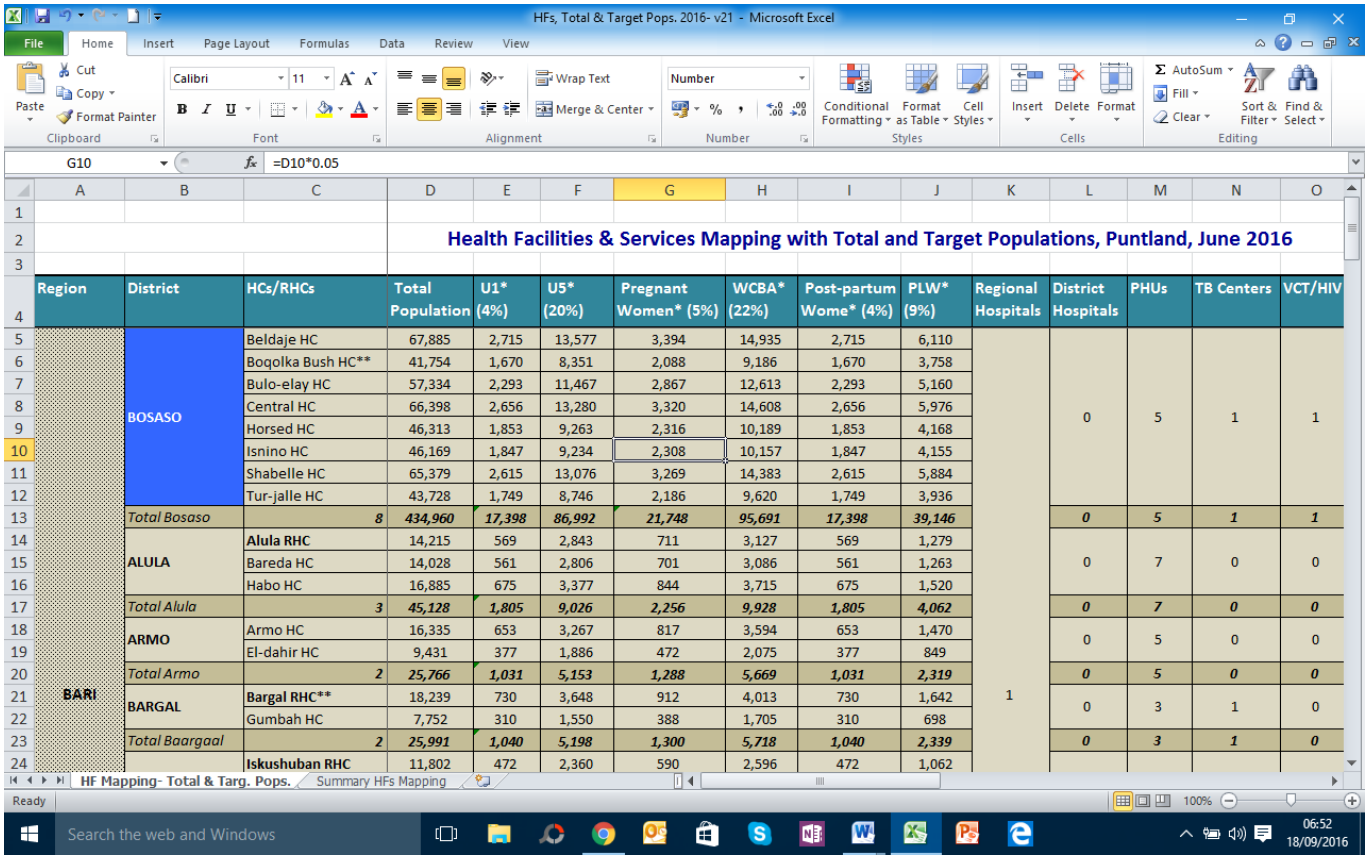


The diagram above, which is the structure adopted by the MoH does not give due recognition for District level systems. With the knowledge that there are a lot of on-going efforts to strengthen District Level HMIS functions, it would be important for the MOH considers revising this structure and the concurrent timelines. Even more important would be for partners to increase investment in developing the institutional capacity for data management at the district level.

It is worth noting that the current HMIS platform uses Microsoft Excel even though there are plans to introduce the District Health Information System (DHIS2). The introduction of DHIS2 is expected to help institutionalize the analysis of data at the District level, consequently improving the application of health data in planning. It is also expected that DHIS 2 will be more dynamic in capturing indicators as opposed to the current situation where the list of indicators

is non-exhaustive, yet the system is rigid. Below is a screen shot of one of the Excel based reporting template.

Diagram: Excel-Based Reporting Template



HFs, Total & Target Pops. 2016- v21 - Microsoft Excel

=D10*0.05

Health Facilities & Services Mapping with Total and Target Populations, Puntland, June 2016

Region	District	HCs/RHCs	Total Population	U1* (4%)	U5* (20%)	Pregnant Women* (5%)	WCBA* (22%)	Post-partum Wome* (4%)	PLW* (9%)	Regional Hospitals	District Hospitals	PHUs	TB Centers	VCT/HIV
BARI	BOSASO	Beldaje HC	67,885	2,715	13,577	3,394	14,935	2,715	6,110					
		Boqolka Bush HC**	41,754	1,670	8,351	2,088	9,186	1,670	3,758					
		Bulo-elay HC	57,334	2,293	11,467	2,867	12,613	2,293	5,160					
		Central HC	66,398	2,656	13,280	3,320	14,608	2,656	5,976		0	5	1	1
		Horsed HC	46,313	1,853	9,263	2,316	10,189	1,853	4,168					
		Isnino HC	46,169	1,847	9,234	2,308	10,157	1,847	4,155					
		Shabelle HC	65,379	2,615	13,076	3,269	14,383	2,615	5,884					
		Tur-jalle HC	43,728	1,749	8,746	2,186	9,620	1,749	3,936					
	Total Bosaso	*8*	*434,960*	*17,398*	*86,992*	*21,748*	*95,691*	*17,398*	*39,146*		*0*	*5*	*1*	*1*
	ALULA	**Alula RHC**	14,215	569	2,843	711	3,127	569	1,279					
		Bareda HC	14,028	561	2,806	701	3,086	561	1,263		0	7	0	0
		Habo HC	16,885	675	3,377	844	3,715	675	1,520					
	Total Alula	*3*	*45,128*	*1,805*	*9,026*	*2,256*	*9,928*	*1,805*	*4,062*		*0*	*7*	*0*	*0*
	ARMO	Armo HC	16,335	653	3,267	817	3,594	653	1,470		0	5	0	0
		El-dahir HC	9,431	377	1,886	472	2,075	377	849					
	Total Armo	*2*	*25,766*	*1,031*	*5,153*	*1,288*	*5,669*	*1,031*	*2,319*		*0*	*5*	*0*	*0*
	BARGAL	**Bargal RHC****	18,239	730	3,648	912	4,013	730	1,642	1	0	3	1	0
		Gumbah HC	7,752	310	1,550	388	1,705	310	698					
	Total Baargaal	*2*	*25,991*	*1,040*	*5,198*	*1,300*	*5,718*	*1,040*	*2,339*		*0*	*3*	*1*	*0*
		Iskushuban RHC	11,802	472	2,360	590	2,596	472	1,062					

HF Mapping- Total & Targ. Pops. | Summary HFs Mapping

Ready

However, beyond the simple process of routine data collection, entry, analysis and audit, which looks well-structured save for a few capacity gaps, there' s a critical need to create linkages of this facility based data, to administrative data and population based data. In order to achieve this, the central government should invest in gathering big data (demographic health information) that helps to situate the status of healthcare - and which have the potential to influence the design of health interventions. Such efforts should include;

3.4.1 Registration of Births and Deaths

The coverage for birth registration among children aged <5 in Puntland is estimated to be only 3% (MICS2006). Similar data does not exist for Bosaso District, however, as part of the HSSP, a

registration system of births and deaths is planned for pilot in some districts (Bosaso being one of these Districts). However, there has been little movement towards realizing this plan.

3.4.2 Surveys, Surveillance and Census

The last multiple indicator cluster survey was in 2011, as such, the findings cannot be said to remain relevant in a rapidly changing environment such as Puntland. There are ongoing discussions on conducting regular multiple indicator cluster surveys/demographic and health survey, but these efforts are threatened by constraints of funding. The last census was in 1975; however, the Government and partners conducted a population estimation study in 2014 at regional and district level. There are plans for a health facility assessment using service availability and readiness assessment (SARA) methodology, and for nutritional surveys. However, the need to strengthen routine operational and clinical research remains eminent. Disease surveillance initiatives within the District (like malaria and HIV) are managed by agencies and such data is not anchored/integrated within the broader HMIS system.

3.4.2 Program and Policy Reviews

The current HMIS system is not designed to gather data that helps in determining the progress made in various Central and District level frameworks, and plans. The need to track the implementation of these programming instruments has not been given prominence, which explains the inadequacy of data around the progress on the HSSP, and most frameworks. Where such data exists like in the case of RH policy, they are often commissioned by an agency and the outcome is with the relevant department(s) and not at a central HMIS repository – which needs to be established. Most partners and donors plan independent monitoring and evaluation of some health sector components or program. Like the JAPR by WHO, review of the GAVI program, and the midterm review of JHNP. Bosaso District health team should consider integrating the monitoring of the District Health Strategic Plan into its information system.

In addition to those already mentioned above, some of the other challenges in HMIS include:

- Inadequate feedback at all levels mainly due to the absence of an information sharing platform/portal. There would be value in conducting regular review meetings at the District level to share feedback from reports.
- Insufficient capacity in data management at the district level. There's a shortage of personnel to conduct data verification and routine quality audits, there's an inadequacy of data processing skills within Bosaso district, and there's need to invest on infrastructure such as computers and databases.
- Low utilization of data for evidence based planning and allocation of resources, and linking the District level HMIS system with the LMIS might be a good place to begin.
- Inadequate allocation of resources to support HMIS activities by the MOH, instead, the HMIS function is supported almost entirely by WHO and other non-state actors.
- The absence of a strategic plan (both at the central and district levels) to guide HMIS operations means the function does not have the much needed roadmap and measurable SOPs and performance indicators.

3.5 Health Financing

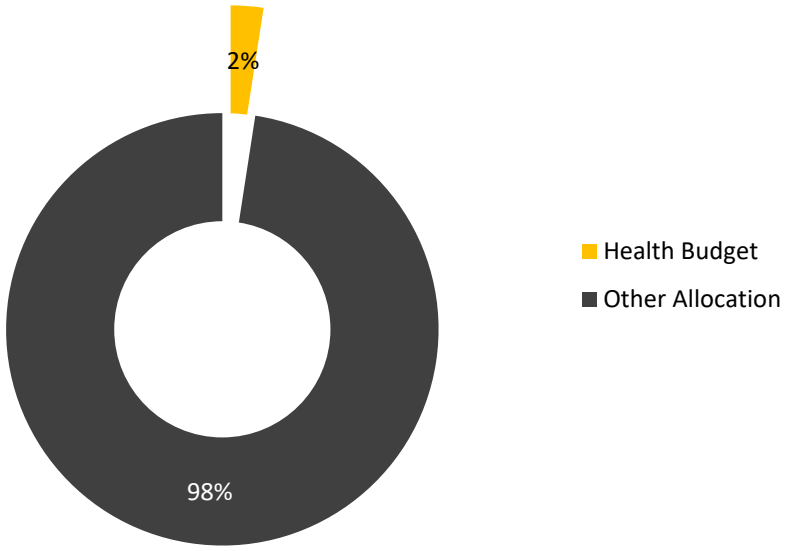
There has been a significant increase in funding for the health sector in Somalia over the past 10 years[29]. Financing from conventional donors has increased by 180%, from US$ 53.6 million in 2005 to US$ 103 million in 2009, reaching approximately US$ 150 million in 2015.[30]

Health functions in Bosaso District (just like the rest of Puntland) are predominantly sustained by external funding from donors through JHNP, GAVI, GFATM and other disease specific interventions. In practice, external financing by far exceeds the governments' contribution. Such external funding is often bilateral and remain unconsolidated, which makes it difficult to appropriate the total Annual Health Expenditure in Puntland, and it's twice more difficult to obtain figures for Bosaso District. In 2014, the annual health budget for Puntland was USD 1million out of a total budget of USD41million, which translates to 2% of the Annual Government Budget far short of the 15% budgetary allocation that is recommended. It is also not clear how much of the USD million is allocated to the specific Districts.

[29] World Bank, 2010, A decade of AID to the health sector in Somalia (2000-2009)
[30] WHO Mission estimates

Per capita public expenditure on health is approximately US$ 10–12 per person per year, which is far below the global standard for health sector investment which should be at least USD 34 per capita based on the WHO-Commission on the Macroeconomics of Health (CMH). The authorities are conscious of the inadequacy of this allocation and there are efforts to increase the share of health budget to 6% by the end of 2018. To achieve this, some of the streams of revenue suggested include; expanding voucher systems, taxing cigarettes and Khat, charging fees for health providers and recovering costs through user fees. Concurrently, community co-financing approaches and public private partnership are also under consideration.

Chart: Puntland Health Expenditure as a share of Total Annual Budget in 2015



There is an urgent need to establish a central reporting system and data-base of the expenditure on health. This will improve financial planning and buttress efforts to improve accountability for within programs - by the Ministry and by the development partners. This joint mechanism to consolidate and capture health budgets and expenditure will lead to improvements in planning, consultations and bolster MOH ownership. More evidently there is need for an urgent National Health Accounts (NHA) study to be able to put into unquestionable perspective the extent of contribution of each of the actors – Government, External Sources, The Private Sector, and Household/Out-of-Pocket health expenditure. The

NHA should also be able to recommend a comprehensive roadmap towards increasing per capita expenditure on health.

Other observations made in relation to health sector financing include:

- EPHS makes up for the bulk of external funding for health in Bosaso and the larger Puntland. Based on a costing study conducted for DFID by Health &Education and Advice Team (HEART) in October 2014, amortised per capita spending on EPHS averages between USD 5.30 and USD 6.85. The most costly of the EPHS services is normal delivery (ranging from USD 30 to USD 67 per delivery), ANC/PNC (USD 8.30–USD 17.68 per pregnant woman), Expanded Programme on Immunisation (EPI) (USD 10.20–USD 22.40 per treated case), and pneumonia (USD 8.78–USD 21.42 per treated case). In the absence of any past costing studies focusing on Bosaso District, and without any major deviations of EPHS approach and strategy, it is acceptable to adopt these figures as the most indicative of the cost of EPHS services in Bosaso District – for use in normative costing. However, more advanced economic analysis and assessment of Value for Money (VfM) should be conducted and applied to resource decision-making at the Regional and District levels. Other interventions supported within the GAVI and GFATM should equally be costed.

- There is very minimal, unconsolidated data on the distribution and utilization of resources to the various health functions, e.g. curative health, preventive health, recurrent expenditure, health research, etc. It is even more difficult to obtain these lines of expenditure at the District level. This speaks to the need for critical reforms in the management of health sector finances.

- A big part of the health budget is targeting SRH activities. This is reflected in stated priorities of the HSSP, SRH Policy as well as the EPHs and JHNP. The health system infrastructure also reflects a bias in SRH, e.g., the core focus of the 8 HCs is maternal and child health care. It is not possible with the available information to assess how much of the financing ends up in SRH activities, but it's clear that the bulk of it does.

3.6 Essential Medicines

Puntland does not have a well-functioning supplies management system that is independent of The UN agencies and nongovernmental organizations. These organizations provide medical supplies to public health facilities as part of their humanitarian and emergency interventions. The Ministry of Health's central warehouse based in Garowe receives and distributes drugs that are donated through non-traditional donors. However, there are indications that the warehouse does not have a proper inventory system, even though standard operating procedures for warehouse management and storage practices have been introduced.

At the Central level, drugs that are purchased by UNICEF and donors under the EPHS framework are managed separately through a parallel supply chain often as a pre-packed kit system, with little coordination and integration (Push System). This system often results in stock-outs and oversupply of medicines and equipment that are not appropriate or in use. The drugs also take longer to purchase and distribute due to complex procurement procedures at UNICEF, and infrastructural challenges in Puntland. Medicines for malaria, HIV, Expanded Programme on Immunization and nutrition are supplied based on request. This also applies to UNFPA's reproductive health kits.

In Bosaso District, MdM provides oversight of the supplies chain and have made significant progress towards a demand/need based supply system (Pull System). All the 9 facilities in the District have drug stores with proper shelves, proper inventory, and sufficient cold storage facilities. MdM monitors the supplies management system closely and frequent drug use reports are generated by the facilities. However, there are incidences of stock outs for Malaria (line 1 treatment) and antibiotics. A supply of vaccines and FP pills is optimal.

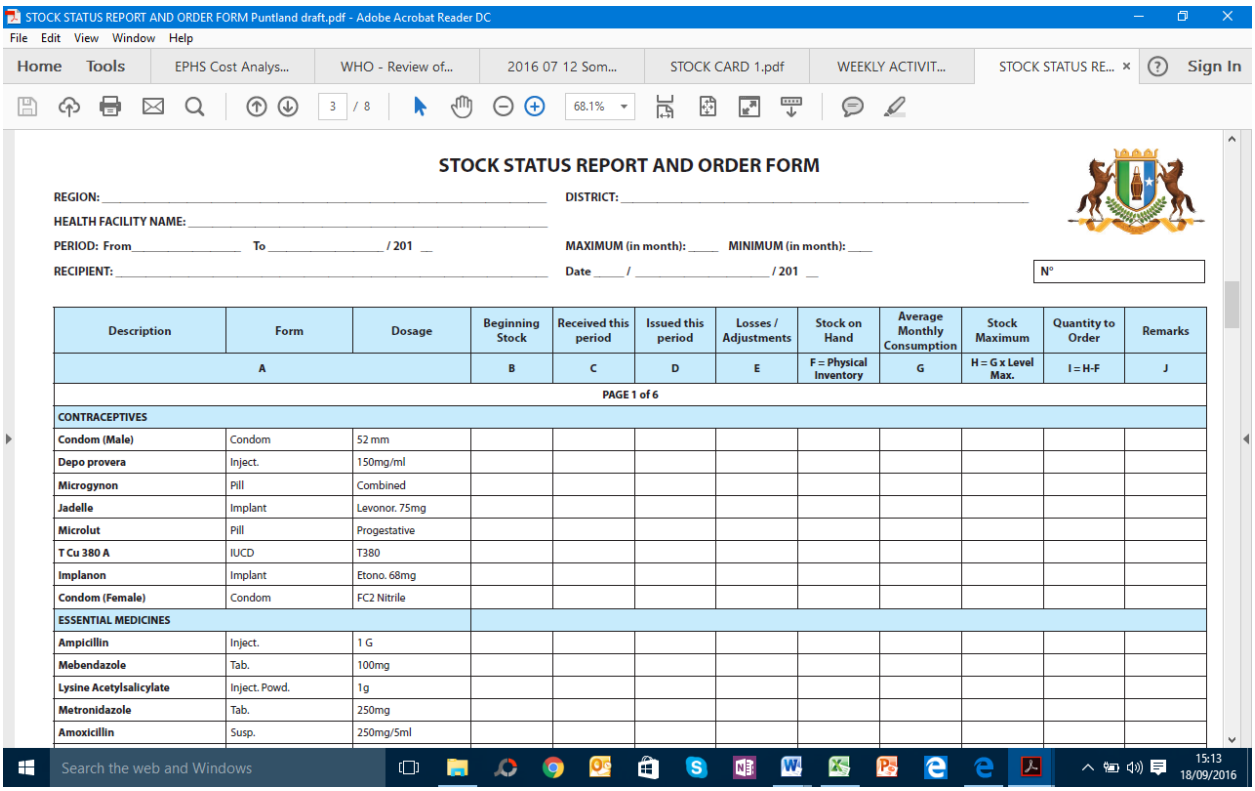
A regulatory system of the pharmaceutical sector does not exist (is not functional) in the District, and throughout Puntland. It is estimated that the private sector provides around 80% of the country's medicines through importation and distribution through private retail outlets and pharmacies[31]. Given this scenario, addressing the issue of safety of the medicines that are

[31] WHO –Review of Somali health sector 2015

sold in the private sector needs to be an urgent priority. This means the controls of the flow of medicines need to be tightened. Tougher public health laws may need to be considered.

It is however important to mention that there are on-going efforts to introduce a Logistics Management Information System (LMIS), and link it to the HMIS at the District level. This, if fully implemented, will have a profound effect on the flow of medical supplies and pharmaceuticals. Already, tools have been prepared as part of the system, but there are still chronic gaps, in the capacity of staff, in the supply chain that the MoH needs to address. Below are a few examples of existing tools (Some of these tools are yet to be introduced to the facilities, instead facilities in Bosaso use MdM provided tools).

Diagram: Samples of Essential Drugs Tools



STOCK STATUS REPORT AND ORDER FORM Puntland draft.pdf - Adobe Acrobat Reader DC

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STOCK STATUS REPORT AND ORDER FORM

REGION: _____ DISTRICT: _____

HEALTH FACILITY NAME: _____

PERIOD: From _____ To _____ / 201 __ MAXIMUM (in month): ____ MINIMUM (in month): ____

RECIPIENT: _____ Date ____ / _____ / 201 __ N°

Description	Form	Dosage	Beginning Stock	Received this period	Issued this period	Losses / Adjustments	Stock on Hand	Average Monthly Consumption	Stock Maximum	Quantity to Order	Remarks
A			B	C	D	E	F = Physical Inventory	G	H = G x Level Max.	I = H-F	J
PAGE 1 of 6											
CONTRACEPTIVES											
Condom (Male)	Condom	52 mm									
Depo provera	Inject.	150mg/ml									
Microgynon	Pill	Combined									
Jadelle	Implant	Levonor. 75mg									
Microlut	Pill	Progestative									
T Cu 380 A	IUCD	T380									
Implanon	Implant	Etono. 68mg									
Condom (Female)	Condom	FC2 Nitrile									
ESSENTIAL MEDICINES											
Ampicillin	Inject.	1 G									
Mebendazole	Tab.	100mg									
Lysine Acetylsalicylate	Inject. Powd.	1g									
Metronidazole	Tab.	250mg									
Amoxicillin	Susp.	250mg/5ml									

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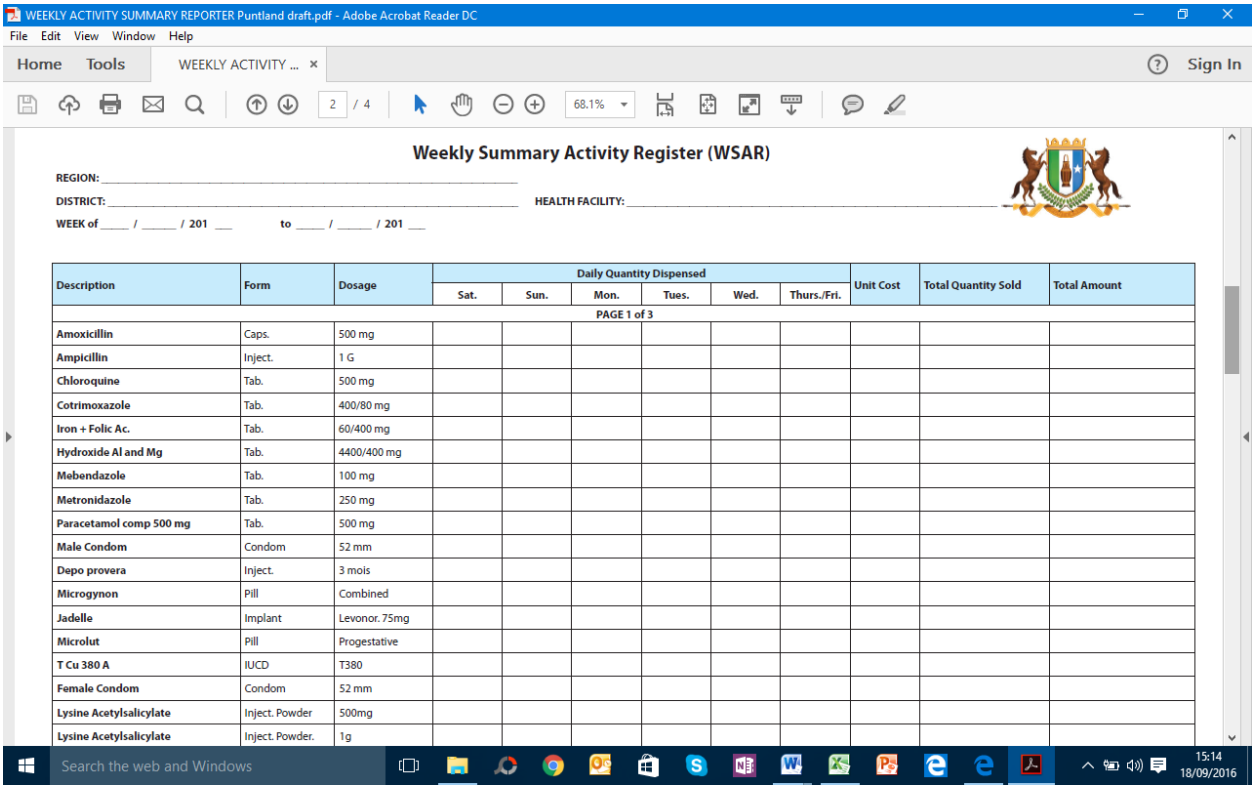

WEEKLY ACTIVITY SUMMARY REPORTER Puntland draft.pdf - Adobe Acrobat Reader DC

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Weekly Summary Activity Register (WSAR)

REGION: _____

DISTRICT: _____ HEALTH FACILITY: _____

WEEK of ____ / _____ / 201 ___ to ____ / _____ / 201 ___

Description	Form	Dosage	Daily Quantity Dispensed						Unit Cost	Total Quantity Sold	Total Amount
			Sat.	Sun.	Mon.	Tues.	Wed.	Thurs./Fri.			
PAGE 1 of 3											
Amoxicillin	Caps.	500 mg									
Ampicillin	Inject.	1 G									
Chloroquine	Tab.	500 mg									
Cotrimoxazole	Tab.	400/80 mg									
Iron + Folic Ac.	Tab.	60/400 mg									
Hydroxide Al and Mg	Tab.	4400/400 mg									
Mebendazole	Tab.	100 mg									
Metronidazole	Tab.	250 mg									
Paracetamol comp 500 mg	Tab.	500 mg									
Male Condom	Condom	52 mm									
Depo provera	Inject.	3 mois									
Microgynon	Pill	Combined									
Jadelle	Implant	Levonor. 75mg									
Microlut	Pill	Progestative									
T Cu 380 A	IUCD	T380									
Female Condom	Condom	52 mm									
Lysine Acetylsalicylate	Inject. Powder	500mg									
Lysine Acetylsalicylate	Inject. Powder.	1g									

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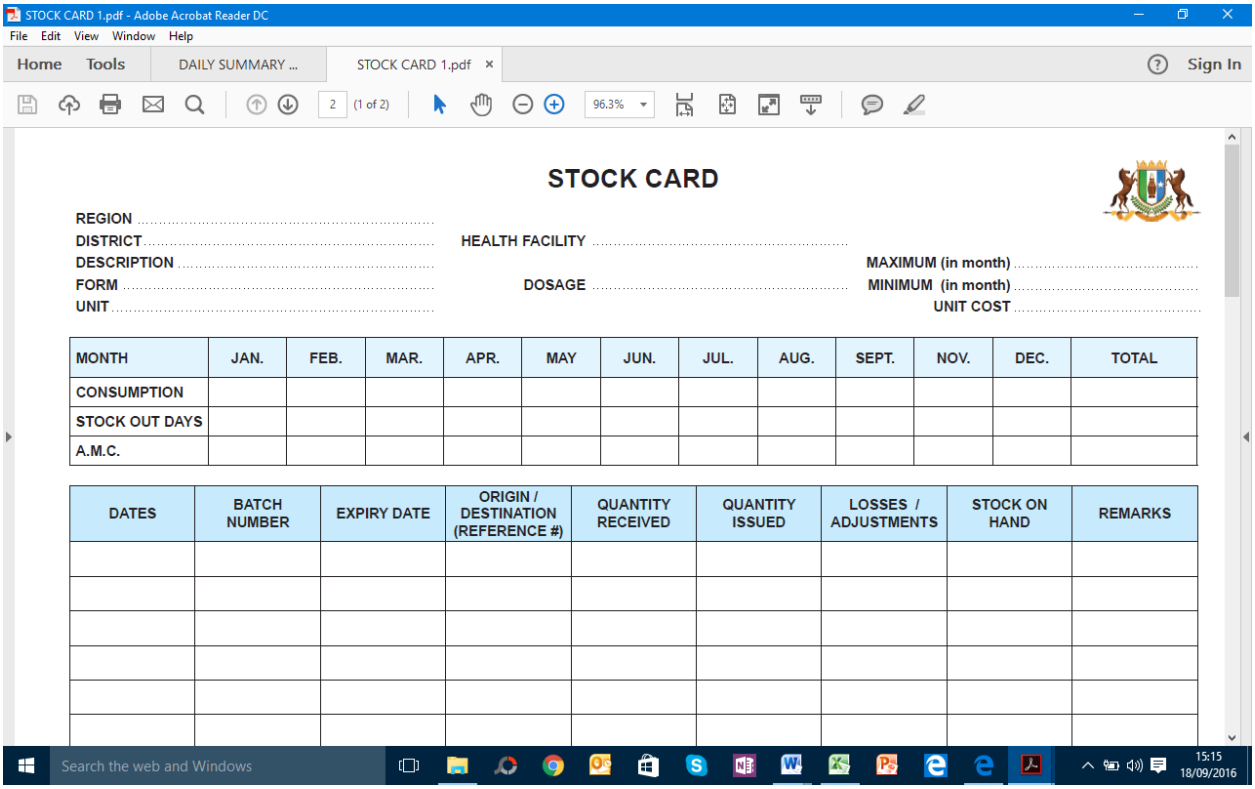

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STOCK CARD

REGION .....

DISTRICT ..... HEALTH FACILITY .....

DESCRIPTION ..... MAXIMUM (in month) .....

FORM ..... DOSAGE ..... MINIMUM (in month) .....

UNIT ..... UNIT COST .....

MONTH	JAN.	FEB.	MAR.	APR.	MAY	JUN.	JUL.	AUG.	SEPT.	NOV.	DEC.	TOTAL
CONSUMPTION												
STOCK OUT DAYS												
A.M.C.												

DATES	BATCH NUMBER	EXPIRY DATE	ORIGIN / DESTINATION (REFERENCE #)	QUANTITY RECEIVED	QUANTITY ISSUED	LOSSES / ADJUSTMENTS	STOCK ON HAND	REMARKS

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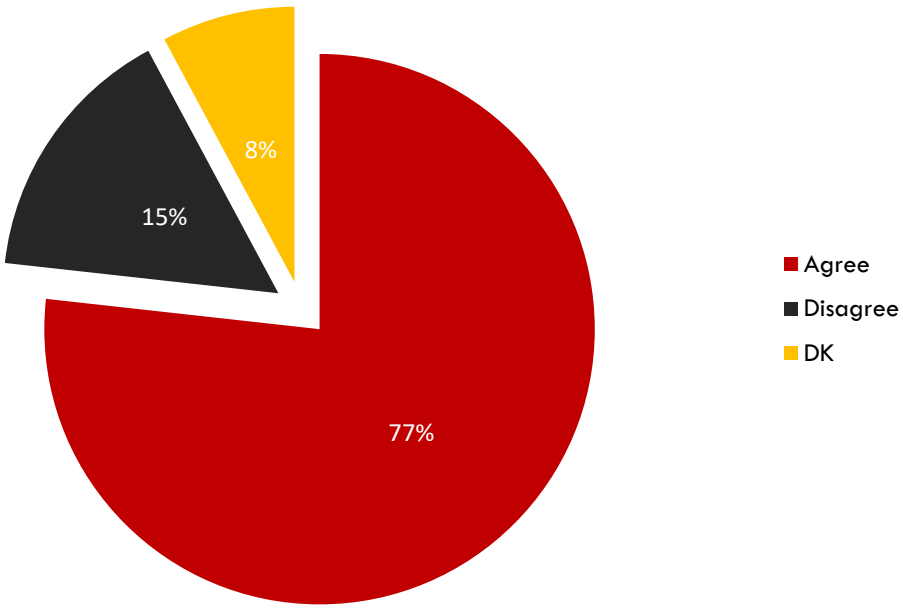
It would be safe to conclude that the essential medicines block is quite undeveloped and requires a great level of investment to establish its key components. The issue of parallel drug management systems needs to be urgently addressed, by doubling efforts to support the MoH in building internal capacities necessary to fully manage the supply chain. For example, a pharmaceutical department needs to be established. It is difficult to comprehend that a pharmaceutical unit has not been provided for in the new MoH structure.

Reflecting the health system's special focus on SRH, drug for reproductive health related conditions are relatively well supplied. UNFPA supplies reproductive health care kits, but uptake is slow indicating entrenched attitudes towards modern family planning methods.

CHART: The health facility has all the medicines and equipment to make delivery safe



4. LIMITATIONS OF STUDY

The Primary Health Units: Due to challenges associated with security, it was not possible to visit the primary health units. The visit to these facilities would have assisted in identifying gaps in community/grassroot health initiatives, especially community health education in rural populations. This report therefore fails in generating information on the outlook of operations at the PHUs. However, there is evidence and precedence that investing on District level structures have a direct progressive effect on Level One (1) health interventions.

Pre-existing Data: In numerous instances, district level data on budgets, the costing of specific health programs and private health facilities is missing. There is also a critical absence of reliable demographic data on population estimates (broken down by gender and age groups), birth rate/death rate, household sizes, and expectancy in life years, etc. Where such information exists, it is neither gathered nor organized periodically therefore it was difficult to draw a comparative analysis over years - in order to project trends that could be useful in planning for routine programs. However, this gap is acknowledged by the regional and district health management teams and there is a profound commitment to strengthen an Integrated District level Health Management Information System.

The Seasonal Calendar: The study was conducted during summer with average temperatures of 38 degrees Celsius. During this time, most habitants of the district migrate to cooler locations, and all systems, including those of health and education operate at a bare minimum. In addition, the afternoon hours of the day are mostly unproductive as a majority of inhabitants prefer to stay indoors - which explains (in part) why the Health Centres close at 1230hrs. However, based on the approach and methodology adopted for the study, there is no reason to conclude that the study would yield different results were it to be conducted at a different time of the year.

5. RECOMMENDATIONS

5.1 Leadership and Governance

- **Policy:** In order to improve the understanding and implementation of the various guiding policies, frameworks and plans, there is need to increase awareness of policy documents at lower levels of the structure. This can be achieved by integrating activities that purpose to monitor policy implementation and by investing in periodic joint reviews of the guiding documents.

- **Coordination:** The joint planning and review meetings need to be regular at all levels. While quarterly meetings are held at the Central level, the coordination meetings at the District level are often based on need and are irregular. This poses a challenge to consolidated response, and reduces benefits that can be drawn from closer linkage amongst partners, like better resource management, complementarity of skills, and sustaining the focus on high impact interventions.

- **District Level Structure:** There is an overlap in the functions of the Regional health team and the District team largely due to varied capacity gaps at the District level. There is need to dedicate efforts to strengthen the District structure investing in; operational infrastructure (offices and equipment), staff capacity (in skills and numbers) to manage the district health functions, and in resource development and management. The District also need to be supported to establish different departments including the department of Reproductive Health.

- **Community Engagement:** In order to buttress community participation in health planning, and consequently contribute to increments in the uptake, ownership, and longevity of primary health care programs, the approaches to community engagement

need to be deliberate, and a framework to guide community level interventions, that establishes and strengthens community health committees, and which increases funding for community health education is necessary. Absolute community involvement can particularly be very useful in interventions for Family planning, and for efforts against FGM.

5.3 Service Delivery

- **Access amongst rural populations:** Considering all the Health Centres and Referral Health Centres are concentrated within urban environments (only a few kilometers apart), yet rural populations only have access to PHUs. While this model makes strategic (priority) sense in the short term due to high density in urban populace, the system needs to constantly strive to reduce inequities in access to essential health services. There is therefore need to double-up on efforts to develop innovative health delivery models to reach rural communities. Short term measures could be improvements in the referral system (including ambulance services), and regular mobile clinics.

- **Service Protocols:** There is an adequacy of protocols for services within the facilities and which are well understood amongst the health workers. The Somali Standard Treatment guidelines (2016) developed by MOH/WHO is one of the most popular with most health workers. However, there is need for routine monitoring efforts to check the adherence levels for all guidelines and protocols.

- **Private Health Services:** It remains unclear the range, quality, and reach of services provided by the private health facilities. This information is not gathered explicitly nor implicitly. The MoH urgently needs to put into place both policy and administrative procedures to gather data from these facilities, and institute regular quality assurance checks.

5.3 Workforce

- **Training:** The trainings institutions need to be supported to improve efforts towards the standardization of courses for various health disciplines. Further, there is need to improve coordination between the MOH and the training institutions in order to ensure that the courses offered respond to skill gaps within the health system. There is potential for increased Public Private Partnership in training of health workers.

- **Staff Motivation:** Different non-profits offer incentives to some health workers at varying rates (for similar positions. There is need to work towards a harmonized pay structure to ensure MoH still retains control of the health system workforce. In addition the MOH needs to consider introducing a non-monetary reward system to recognize exemplary performance. One of the many ways of motivation could include up-scaling of on-the-job training.

- **HR Audit:** A needs assessment to ensure systematic response to the gaps in the workforce in the district is highly necessary. A comprehensive job evaluation needs to be conducted within the District in order to create clarity and quantify the skill gaps in the workforce and to recommend strategies for capacity improvement.

5.4 Financing

- **Costing of Services:** The only costing study conducted has been for EPHS in Puntland as a whole without focusing on Bosaso District. It is recommended that a costing study be conducted for other programs such as Malaria, TB and HIV, as well as for community health education. Understanding the cost of each of these health functions will ensure that resources are optimally distributed;

- **Finance Management System:** The finance management functions in Bosaso are at infancy, and needs to be built from the ground up. Structures for financial management and coordination needs to be instituted. The presence of a financial management system to increase donor confidence levels thus increasing the ability of the District to independently mobilize resources for health programs. At the same time, the presence

of such a system will enable the consolidation of health budgets and expenditure outlook (from the government, NGOs, private sector and service recovery) at the District level. A central finance reporting system will empower the MoH in planning, budgeting and steering of sector reforms.

5.5 Essential Medicines

- **The LMIS:** On-going efforts to introduce the Logistics management system should be escalated. The introduction of this system will help monitor facility level consumption of drugs and help to perpetuate a need based system of supplies. It should be accompanied by an inventory system to augment operational warehouse management and storage practices.

- **A Pharmaceutical Board:** in order to regulate the purchase and flow of medicines, it is important to establish a body of authority to provide oversight and technical support to private health facilities and to monitor operations of private pharmacies. This Board should be established at the Central level with operations devolved to the regions and districts.

5.6 Information Systems

- **Analysis, Feedback and Utilization of data**: It would be useful to support staff capacities, and ICT infrastructure, such as computers and databases, within the district so that analysis of data can take place at the district level. There is added value in conducting regular review meetings at the District level to share feedback from reports. It is expected that the comprehensive analysis and feedback of data will optimize the utilization of data for evidence-based planning and in the allocation of resources.

- **Vertical programs vs Big data:** The integration of data from vertical programs into the HMIS system is an urgent need. The system needs to capture progress made in these vertical programs using data generated directly by the facilities. This will require a revision of the existing data collection tools/registers. In addition, the health information system needs to consider intensifying efforts to strengthen surveillance systems, organize/incorporate data from various health surveys, and continue the push for a complete Demographic Health Survey (even if it's just for the District). If achieved,

the District level DHS could be a milestone that donors and other Districts would learn from.

6. PRIORITIZATION AND PROGRAM DESIGN

6.1 The Process

During a two-day workshop, and after a validation of the initial findings, the critical players in the health sector at the Central, Regional, and District levels, were guided through a SWOT Analysis, and a benchmarking exercise in which they used a score card (with predefined attributes and values) to rank their performance on the various elements that constitute the various system building blocks. Since the benchmarking tool (The Health Systems Scorecard), is a detailed descriptive document, it is too long to include as part of the report and below is one of the pages. *The complete tool will be annexed to the final report.*

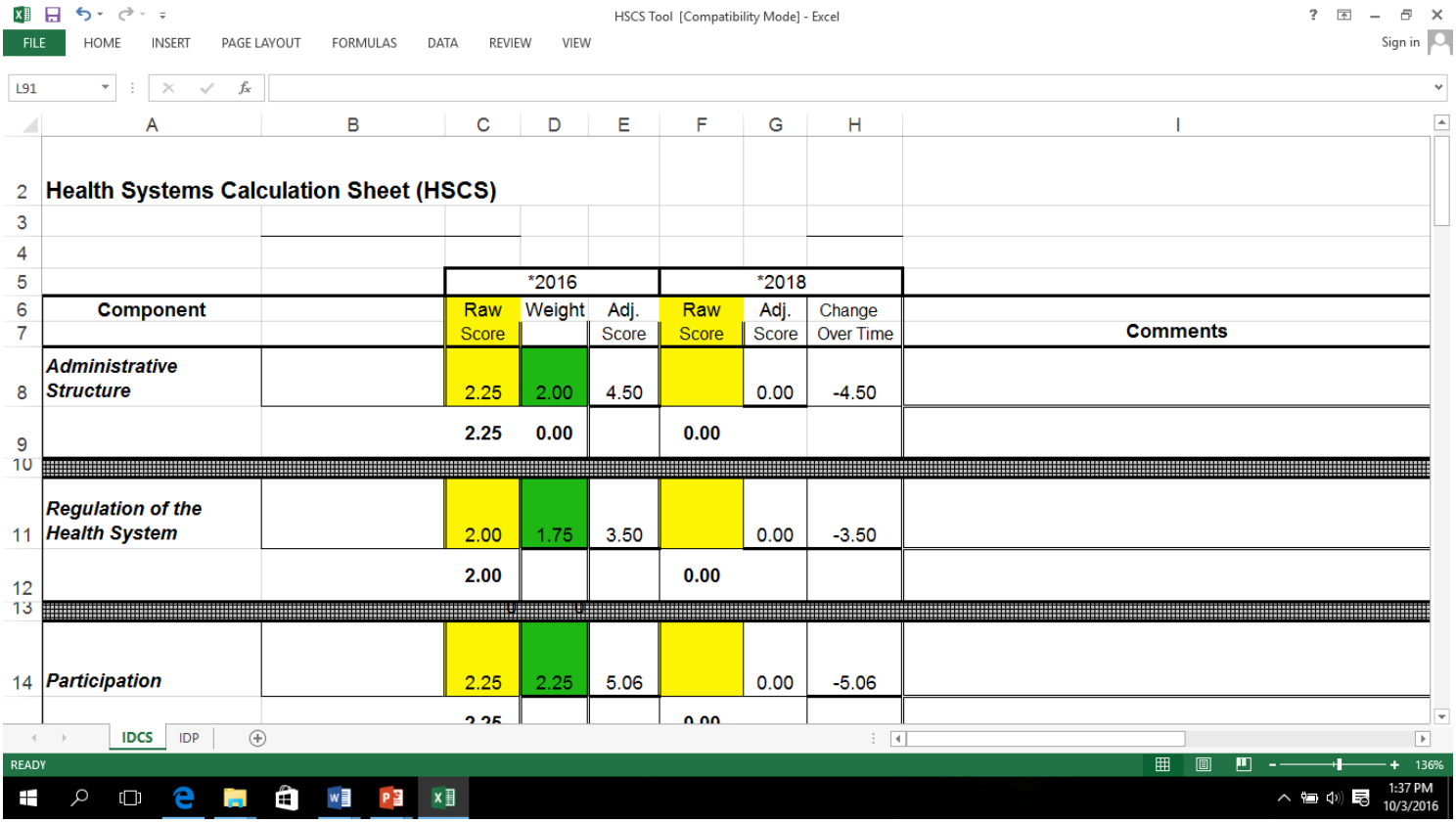
Diagram: Health Systems Performance Scorecard

Health Systems Performance Scorecard

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	Developing	Consolidating	Resilient
	0	1	2	3	4
LEADERSHIP & GOVERNANCE				
Administrative Structure	Administrative structures are adhoc. Structures are unclear and all health decisions are made by a small group of individuals in the Ministry and a few organizations	There is a defined structure at some levels, however roles are not very well defined and there are incidences of overlaps.	There is an operational body at National/Regional and District level for managing health operations. However, there are gaps in the manner they coordinate the implementation of policies, strategies and plans	There is a perfectly functioning operational body at National/Regional and District level (with well defined roles) for managing health operations, and which effectively coordinates and supervises the implementation of policies, strategies and plans
Regulation of the health system	There is a shortage of laws, policies, plans, and procedures, and the available ones are neither implemented, nor reviewed.	The existing laws, policies, plans, and procedures are inadequate in managing healthcare, despite the fact that some of them are being implemented.	There are laws, policies, plans, and procedures which are adequate in managing healthcare, but which are not being fully implemented, and are not reviewed consistently.	There are laws, policies, plans, and procedures which are adequate in managing healthcare, and which are being implemented, and are reviewed consistently.
Participation	Planning for health programs and activities is top-down	The participation of Stakeholders in planning is widened with contributions to decision making.	Communities and stakeholders provide information for planning of health programs, but are excluded from decision making.	Communities and Stakeholders contribute to planning decisions along the Ministry of Health Leadership. Non-health sector actors are involved in the development and implementation of the health policy

Upon ranking, the scores agreed in plenary are entered into a worksheet with formulas calculated to display the mean performance of each system building block. Below is an impression of the Health Systems Calculation Sheet (HSCS).

Diagram: Health Systems Calculation Sheet



6.2 Results

6.2.1 SWOT Matrix

SYSTEMIC FACTORS [INTERNAL]

CONTEXTUAL FACTORS [EXTERNAL]

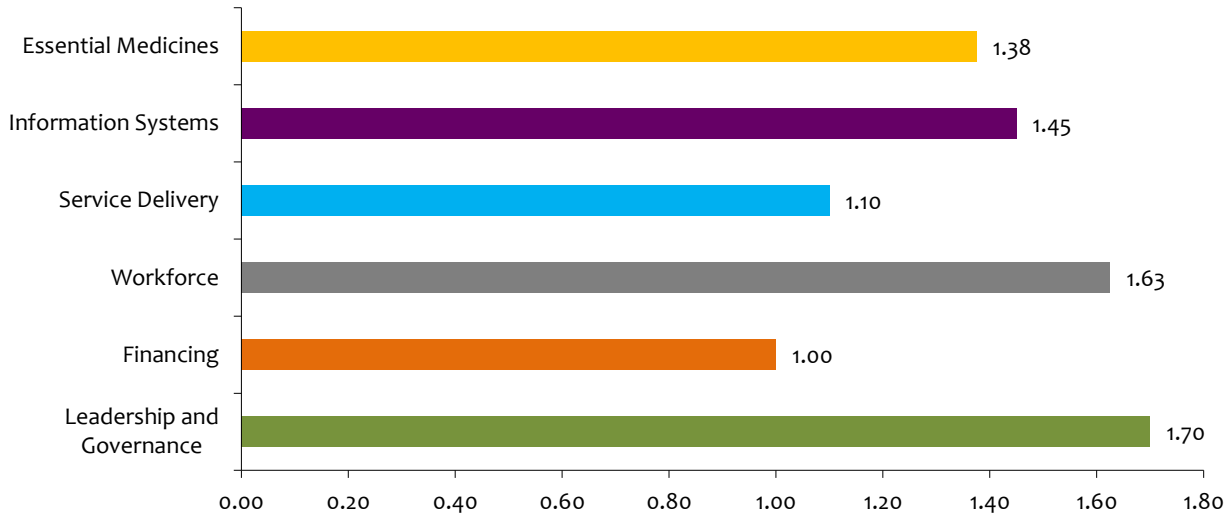
STRENGTHS:	WEAKNESSES:
▪ Presence of a sufficient network of health facilities in urban environments ▪ The delivery of free Primary Health Care services complemented by a cost-recovery system for Bosaso General Hospital ▪ Presence of emergency preparedness units ▪ Well-structured Health Management Systems ▪ Standardized HMIS Tools in all facilities with reports generated regularly ▪ Supportive NGO partners who support various specific health system functions (including human resource, management of supply chain)	▪ Unclear/overlapping roles and responsibility between regional and district level teams ▪ Inadequate capacity for monitoring and support supervision – which makes it challenging to monitor adherence to SOPs ▪ Limited health infrastructure like ambulances, laboratories, radiology equipment, ICT, etc ▪ Low investment of on community level health investments especially community health education. ▪ Inadequate staff capacity (in numbers and skills) to respond to the various health needs – which leads to a heavy work load for existing health workers. ▪ Absence of other (Non monitory) motivation alternatives, like trainings, awards, foreign skills exchange trips, etc. ▪ Donor dependence due to low government contribution towards healthcare. ▪ Top down management system of supply drugs (supplies are not based on need because they are not bought with the in-puts from health facilities) ▪ Capacity gaps in the analysis, feedback and consumption of data at the District level. ▪ High staff attrition due to low incentives in the health institutions.

OPPORTUNITIES:	THREATS:
▪ Commitment from donors, governments and all stakeholders towards various programs and initiatives ▪ Presence of Training institutions & Universities keen to contribute to building skilled workforce ▪ Contribution and influence of the diaspora ▪ An active private health sector which reduces pressure on the public facilities, consequently contributing to progress on various indicators	▪ Health programs that lack without exit strategies, consequently becoming unsustainable ▪ Climate related problems that affects the coverage of the services. ▪ Refuges and returnees which places a greater burden on the healthcare system

6.2.2 System Scorecard

The graphs below are illustrations of the performance of the health system blocks and the individual components as scored by the stakeholders during the highly participatory program design workshop.

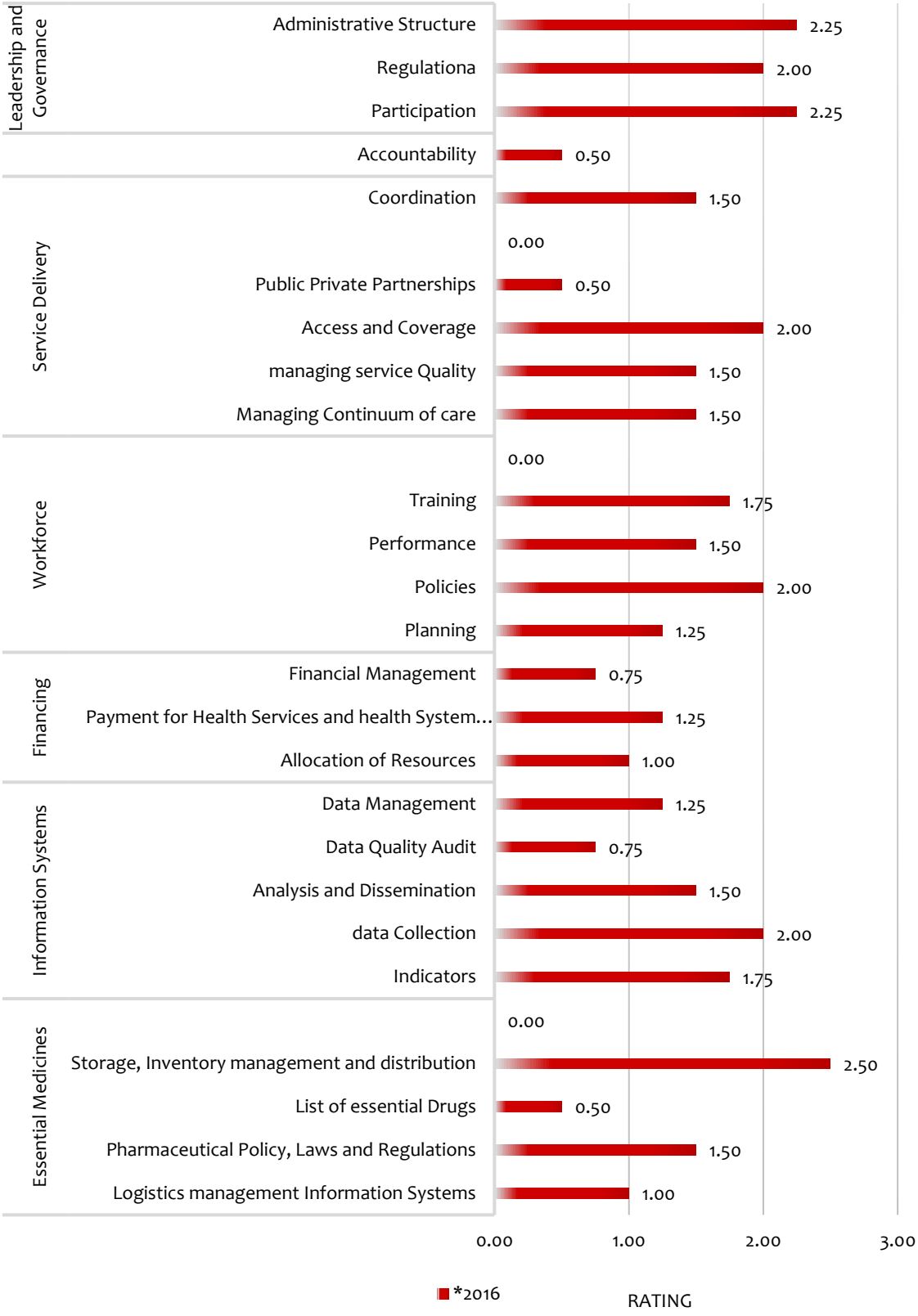
Graph: Average Score Placement by System Building Block (Out of a maximum score of 4 points)



Based on the scores above, it is evident that the Health system in Bosaso District scored less than 50% (2 unit points) in all the building blocks. Put differently, it is accurate to conclude that the system has gaps in all areas and significant investment is required for each individual block (with varied levels of priority). Nonetheless, efforts to strengthen the health system needs to appreciate that there is tremendous commitment and desire by the Ministry of Health team(s), and NGO partners to improve the system. Rather than institute parallel programs, donors and implementing agencies need to consider the integration of programs, and increment of direct investment into improving capacities within the MoH - where challenging, any political, policy, or strategic complexities should be discussed.

The average placement depicted in the graph above is generated from the scores in the individual sub-components as indicated in the visualization below.

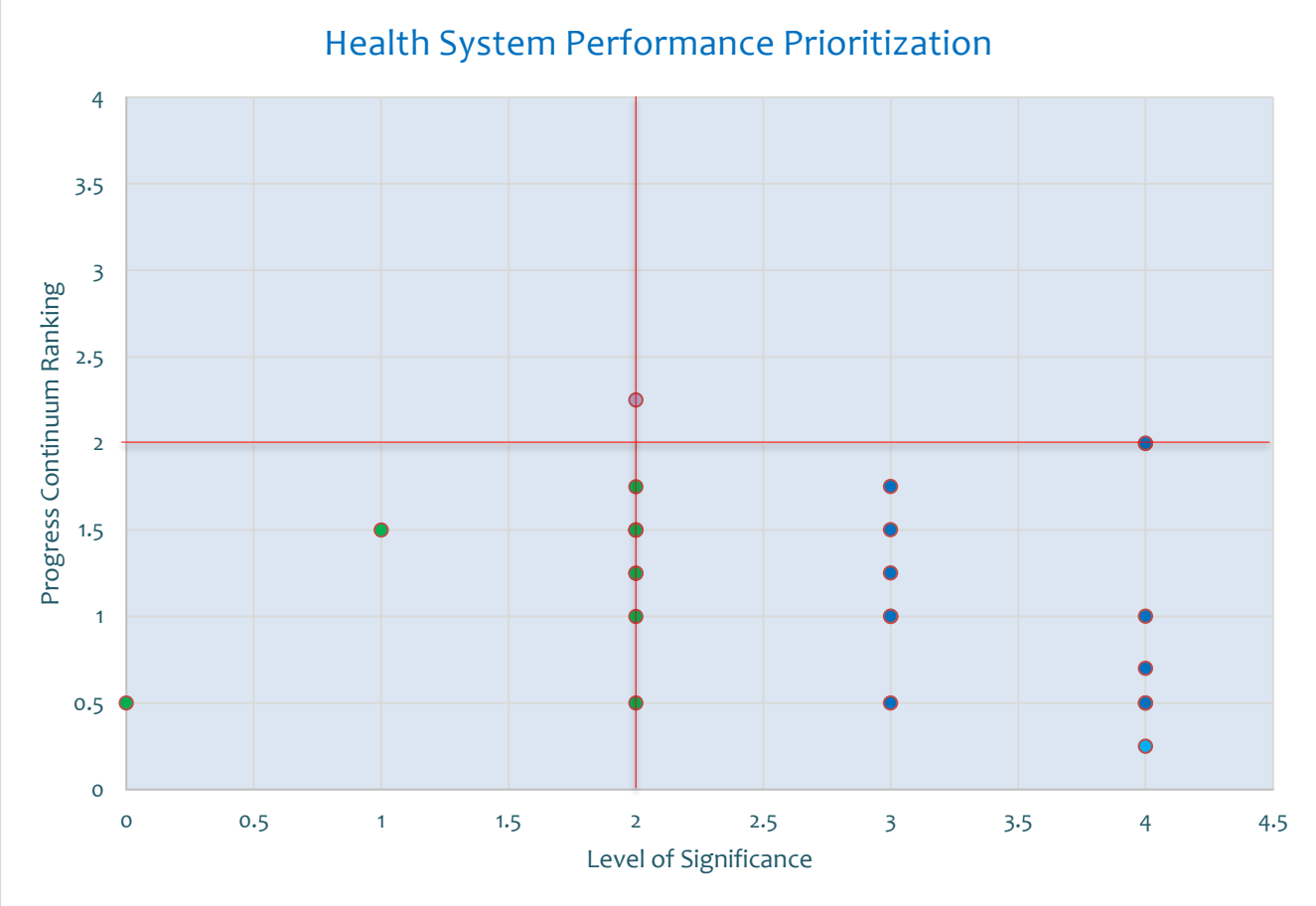
GRAPH: VISUALIZATION OF SUB-COMPONENTS



6.2.3 Prioritization

Basing arguments on the findings of the diagnosis, the SWOT analysis and the Scorecard, the various sub components were ranked based on levels significance using an X-Y axis relationship as demonstrated in the diagram below;

Diagram: Health System Prioritization



KEY:

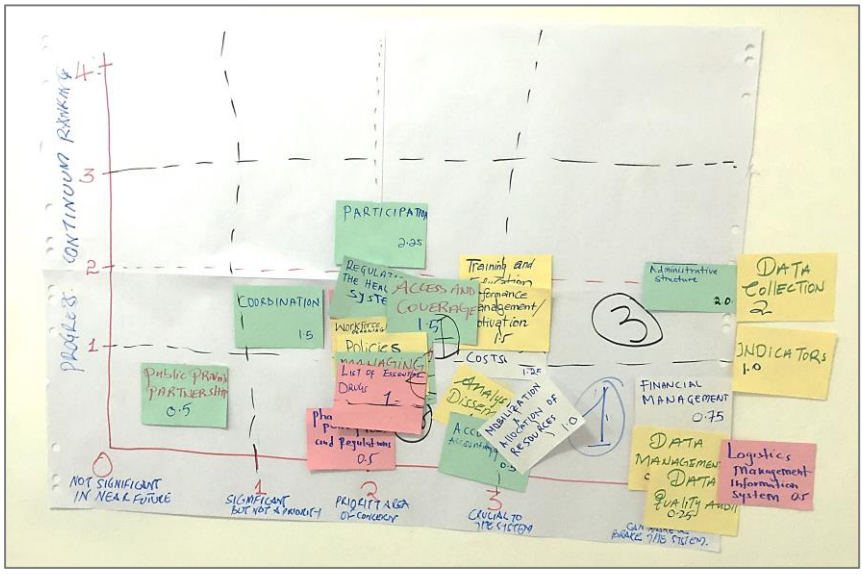
QUADRANT 1: LEAST SIGNIFICANT • Participation	**QUADRANT 2: SIGNIFICANT**
QUADRANT 3: VERY SIGNIFICANT • Public Private Partnership • Coordination • List of Essential Drugs • Access and Coverage • Storage Inventory Management and Distribution • Policies	**QUADRANT 4: MOST SIGNIFICANT** • Mobilisation and Allocation of Resources • Analysis and Dissemination • Accountability • Performance Management/Motivation • Training and Education • Payments for Services and Health

• Managing Service Quality • Regulation of Health Systems • Pharmaceutical Policy, Laws and Regulations • Work Force Planning • Managing Continuum Care	System Costs • Administrative Structure • Financial Management • Data Collection • Logistics Management Information System • Data Management • Data Quality Audit

The process above yielded a list of priority components that have been used in developing a Logical Framework for the strengthening of the Health Systems in Bosaso District (annexed herewith).

Photo: Participants taking part in the health system prioritization process of Bosaso District

Photo: Performance Prioritization Chart



7. ANNEXES

7.1 Programming Strategy Logical Framework

PARAMETER	OVIs	MOV	ASSUMPTIONS
GOAL **Strengthen the District Health System as a means of improving access and quality of essential health services, consequently increasing the surge capacity at the District level.**	• **% Improvement in benchmarking scores** • **Presence of District level health care frameworks (by each building block)**	• **Performance on the Health Systems Scorecard (Benchmarking Matrix)** • **Copies of the various District frameworks**	• **Availability of resources** • **Political good will**
OBJECTIVES – HIGH PRIORITY			
a. To strengthen data management to inform decisions planning and budgeting	• Presence of comprehensive indicator list for all the cohorts • Number of data quality audits undertaken at all district health facilities • Number of capacity development activities undertaken on data generation and analysis • % of HMIS information use in LMIS • Number of periodic review of HMIS tools for	• HMIS monthly reports • DQA reports • Capacity development/ training reports • LMIS reports • Health facility ICT inventory	• Political will for district autonomy • Sufficient HMIS staff at the district level • Political will to link the LMIS with the HMIS • Existence of ICT skills at the health facilities • Availability of electricity and

	improvement • Number of health facilities with modern ICT infrastructure e.g. computers and printers		internet at the health facilities
b. To improve the administrative and management function for effective accountability and coordination of the health system	• Capacity needs established for the District health staff • District-level health management structure with defined roles and responsibilities in place • Number of district staff aware of respective policies, plans and guidelines • % of evidence-based decision making in planning and budgeting at the district level • Presence of a framework for horizontal, agency-to-agency coordination	• Capacity assessment report • Approved District management organogram • Training reports • District plans and budgets • Agency-to-agency coordination meeting minutes	• Political will for district autonomy • Willingness of donor agencies to harmonize their interventions
c. To enhance performance management and motivation of health Human Resource to meet the health system goals	• Ratio of workforce to the Bosaso population • Ratio of health workforce by cadre within Bosaso • Number of staff given in-service training • Level of staff performance • Level of health staff satisfaction level • HR department at district level established • Staff salaries standardized across cadres	• HR audit report • MoH records • Performance appraisal reports • Staff satisfaction surveys • District HR department	• Political will • Willingness by partners to abide by MoH HR guidelines
d. Strengthened financial management system for	• District financial management system in place • Framework for financial decentralization in place	• Financial management reports • District health finance committee	• Puntland's framework for financial decentralizatio

enhanced efficiency and accountability	• Resource mobilization strategy in place • Consolidation guideline of different resource streams in place • Number of budgetary and planning review meetings • Increase of total amount of resources at the district • Presence of a District health committee • Presence of a District finance department • District procurement system in place**	• District finance department • Resource mobilization strategy • Review meeting minutes • District health budgets & plans	n is implemented • Financial management capacity at district level
	OVIs	**MOV**	**ASSUMPTIONS**
OUTPUTS – HIGH PRIORITY			
a. Data management system in Bosaso District that informs decisions in the health system	• Increased capacity of staff to analyze data • Presence of ICT infrastructure in the District • Harmonized indicators • Integrate data from vertical programmes and from private health facilities	• Training reports • Progress reports	**Support will be received from NGOs and the Central government**
b. To improve the administrative and management function of Bosaso District for effective	• Capacity Needs Assessment conducted • Terms of reference for District Health Team • Revised District Management Structure • District team aware key policies, plans & guidelines	• **Capacity Needs Assessment reports** • **Minutes/proceeding of consultation meetings** • **Copies of key policies, plans and guidelines**	**Political will for district autonomy**

accountability and coordination of the health system	• Data from HMIS is used for decision making • Formal consultations between implementing agencies		
c. To enhance performance management and motivation of health Human Resource to meet the health system goals in Bosaso District	• Increased workforce/population ratio • Enhanced Capacity of the health workforce • Increased staff morale and motivation • Payroll standardized • District level Human Resource Department • Staff scheme of service	• **Copies of HR manuals, schemes and assessment reports**	**Willingness by the central government to support the decentralization of HR functions**
d. Strengthened District financial management and accounting system for enhanced efficiency and accountability.	• District financial management and Accounting system • Procurement system • Increased resources for Health • Enhanced efficiency of district health system • A District Health Committee • A District Finance Department	• **Copies of documents describing accounting and procurement systems** • **Finance reports**	**Availability of support from NGOs, Communities and Central government**
	OVIs	**MOV**	**ASSUMPTIONS**
OBJECTIVES – MEDIUM PRIORITY			
e. Improved quality of health training and education	• Regulation framework for health professionals established • Regulatory/Accreditation framework for health training institutions established; • Framework for	• MoH Reports • Review of Training Quality Report*** • MOU between MoH & Training Institutions • Reports from health professional bodies	• Government has capacity/willingness to enforce regulation • Institutions have capacity

	MoH/Training institutions partnerships established; • Number of training institutions using harmonized curricula; • Number of health professionals with professional accreditation;		to improve quality of training
f. Effective participation of stakeholders and communities in design, implementation and review of health interventions	• Guidelines for stakeholder participation in place • Strategy for public communication of health information in place • Number of stakeholder sessions in planning, implementation and review of health interventions • Number of public information and education activities undertaken	• MoH reports • Health programme reports • IEC materials	• Willingness by the government for transparency in public participation
g. Enhanced framework for regulation and use of pharmaceutical products	• Pharmaceutical policy/law in place • Pharmaceutical department established at Central level • Decrease of expired and illicit drugs in the market	• Pharmaceutical policy/law • MoH reports	• MoH has capacity for enforcement
h. Improved access to adequate and quality health care	• % of population with access to health facilities • Number of referral health facilities • Number of health facilities adhering to protocols and standards • Level of community engagement in service provision	• Health access surveys reports • MoH reports	• Availability of resources – financial, human, equipment, ambulances, etc.
i. Optimal /efficient management of drug supply system	• % of drugs supplied on basis of demand/ priorities • % of medical supplies wasted • Link between LMIS and HMIS established	• MoH reports • LMIS reports	• Availability of support from NGOs, and central government

7.2 Health Performance System Score Card

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3 4
LEADERSHIP & GOVERNANCE				
Administrative Structure	Administrative structures are adhoc. Structures are unclear and all health decisions are made by a small group of individuals in the Ministry and a few organizations	There is a defined structure at some levels, however roles are not very well defined and there are incidences of overlaps.	There is an operational body at National/Regional and District level for managing health operations. However, there are gaps in the manner they coordinate the implementation of policies, strategies and plans	There is a perfectly functioning operational body at National/Regional and District level (with well defined roles) for managing health operations, and which effectively coordinates and supervises the implementation of policies, strategies and plans
Regulation of the health system	There is a shortage of laws, policies, plans, and procedures, and the available ones are neither implemented, nor reviewed.	The existing laws, policies, plans, and procedures are inadequate in managing healthcare, despite the fact that some of them are being implemented.	There are laws, policies, plans, and procedures which are adequate in managing healthcare, but which are not being fully implemented, and are reviewed consistently.	There are laws, policies, plans, and procedures which are adequate in managing healthcare, and which are being implemented, and are reviewed consistently.

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3 4
Participation	Planning for programs and activities is top-down	The participation of Stakeholders in planning is widened with contributions to decision making.	Communities and stakeholders provide information for planning but are excluded from decision making.	Communities and Stakeholders contribute to planning decisions along the Ministry of Health Leadership. Non-health sector actors are involved in the development and implementation of the health policy
Accountability	There is no known form of public accountability , nor are there procedures or structures for public accountability	The public are sometimes not informed of major decisions and actions in the health system. Public Accountability structures are not clear.	The public are sometimes not informed of major decisions and actions in the health system. Public Accountability structures are clear and are understood by all.	Informing the public about major decisions and actions in the health system. Public Accountability structures are clear and are understood by all.

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3	4
Coordination	There's no clear record of actors, or their activities. Health stakeholders meetings are rare and they are convened actors to discuss specific issues	Some of the activities of actors are mapped, and are mostly aligned to health sector priorities, strategies and plans. Stakeholder meetings are inconsistent. The MoH have no finances to convene stakeholder meetings and have to rely on partners to do so.	Activities of key actors are clearly mapped, and are aligned to health sector priorities, strategies and plans. Stakeholder meetings are fairly consistent but issue based	Activities of key actors are clearly mapped, and are aligned to health sector priorities, strategies and plans. Health Stakeholder meetings held frequently and consistently.
HEALTH FINANCING				
Mobilization and Allocation of Resources	Joint Annual Plans not developed budgeting not based on annual work plans	Joint Annual Plans developed at the Central level but not cascaded to the District level. Plans are rarely used as budgeting tools, rather, plannign is based on specific funding streams	Annual plans are developed and approved jointly by the MoH and stakeholders. The plans are used as a tool for resource allocation/redistribution	Budgeting is used as a tool for annual planning and management Joint Annual plans are comprehensive and specific enough to permit accurate resource allocation, and flexible enough to be modified as warranted. The plans are reviewed each year.

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3	4
Payments for Services and Health System Costs	Procurement procedures do not exist and single sourcing is prevalent	Procuring /contracting procedures exist but they are rarely followed especially at the lower levels	Procuring /contracting for health service delivery and other health system functions done based on well defines procedures. However, MoH delays in paying suppliers/contrators	Procuring /contracting for health service delivery and other health system functions done based on well defined procedures at all times. Payment of suppliers is done promptly.
Financial Management	Financial resources are mainly controlled by donors. Internal controls are weak.	Financial procedures are established, but still are not fully systematic.	Financial procedures are systematic and established to support operational management. Documented procedures facilitate ongoing controls.	Control is an internal management function. The Ministry does not perceive controls as being excessive
HEALTH WORKFORCE				
Workforce Planning	Too few people are filling too broad a range of professional skills.	Specialists are brought on (or contracted) for core skills areas, but gaps remain	All core skills areas are covered with personnel and external experts	Planning of health workforce deployment and development is realistic and needs-based
Policies	No formal personnel policies and systems (job descriptions, recruitment and hiring procedures, etc.) exist.	Some, but not all, necessary personnel systems exist. Informal practices exist.	Virtually all necessary personnel systems are institutionalized. Occasionally informal mechanisms are used	Formal personnel systems are institutionalized, understood by all health workers and redress can be pursued

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3	4
Performance Management/Motivation	Little or no recognition of staff performance. Health Worker "burn-out" is common.	Performance recognized informally, but no formal mechanisms exist. Support supervision is weak and ad hoc	Formal performance reward system established, but health workers do not participate fully in target setting. Support supervision mechanisms exist	Health workers participate in setting of targets and know what is expected of them. Formal system exists that matches rewards to health worker performance. Support supervision is well structured and well executed
Training and Education	Little or no on the job training provided. No focus given to managing the quality of preservice training programs.	Some training provided. Quality of preservice training programs not managed.	Health workers receive adequate training, and mentoring, but planned staff development still not integrated into Ministry. Quality of preservice training programs some how managed.	Healthworkers with the requisite clinical, technical, and management skills are produced. The quality of pre-service training programs is properly managed.
ACCESS TO ESSENTIAL MEDICINES				
Logistics Management Information System	Non-existent LMIS system, purchase is inconsistent, and distribution is through prepackaged kits	Non-existence of computer based LMIS system, however data is gathered manually and rarely used inform purchase and need based distribution	Presence of an LMIS system but which generates accurate data, but data is often unutilized	Accurate and timely essential data on, stock on hand, rate of consumption, and losses and adjustments is generated and utilized to inform purchases and supplies of essential products

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3	4
Pharmaceutical Policy, Laws, and Regulations	There is a shortage of pharmaceutical laws, policies, plans, and procedures, and the available ones are neither implemented, nor reviewed.	The existing laws, policies, plans, and procedures are inadequate in regulating pharmaceuticals, despite the fact that some of them are being implemented.	There are laws, policies, plans, and procedures which are adequate in managing pharmaceuticals, but which are not being fully implemented, and are reviewed consistently.	There are laws, policies, plans, and procedures which are adequate in managing pharmaceuticals, and which are being implemented, and are reviewed consistently.
List of Essential Drugs	A list of essential drugs has not been updated in more than 12 months	A formal list of essential medicine developed and updated consistent with population health priorities. However, products are not distributed based on the list.	A formal list of essential medicine developed and updated consistent with population health priorities. Products are selected in line of the list but there are frequent stock outs.	A formal list of essential medicine developed and updated consistent with population health priorities. Selecting products in line with the endorsed essential medicine list.
Storage, Inventory management and distribution	Storage is not sufficient at all levels and inventory not regularly updated. Absence of laid down procedures for cold chain Management	Sufficient storage at all levels and distribution procedures are well described. Inventory is kept but distribution is still based on pre-packed kits. There is a structure for cold-chain management – but with shortage of staff or cold boxes	Essential supplies are stored and distributed. Waste of essential medical Products (either due to expiration, damage, or corruption), has somehow been eliminated. There is a functional structure for cold-chain management	Essential supplies are stored and distributed. Waste of essential medical Products (either due to expiration, damage, or corruption), has fully been eliminated. Data is used to inform distribution of products, and the cold chain is effectively managed.
INFORMATION SYSTEMS				

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3 4
Indicators	Indicators are insufficient and are not properly tracked	Indicators are insufficient though often tracked.	Indicators are sufficient and flexible, and are consistently gathered. However, results are not regularly used to inform, policy nor in planning, nor resource allocation.	Evidence on population health needs is fully used to inform policy, planning and resource allocation decisions.
Data collection	Little data is collected, and completion and timelines are off the mark	Some data is frequently and consistently collected from health facilities at all levels. However, there are challenges with timelines, completeness and accuracy with the data collected	Most but not all data is collected in a manner that is timely, complete and accurate.	All required data is collected at all levels in a manner that is timely, complete and accurate. Data collected includes (but not limited to); census data, civil registration data, population-based survey data, data to monitor notifiable diseases ("individual records") , service records/clinical data, etc.

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3 4
Analysis and Dissemination	Data gathered is rarely analysed except based on information demand	Data is sometimes analysed at higher levels of the structure and feedback shared based on need	Data is routinely analyzed and synthesized most levels and results often shared with policy makers, managers, providers, and other stakeholders at all levels and across agencies/departments	Data is routinely analyzed and synthesized to produce useful information about population health status and needs and health system performance. Information is routinely shared with policy makers, managers, providers, and other stakeholders at all levels and across agencies/departments
Data Quality Audit	DQAs are rarely conducted. HMIS do not have capacity to conduct rigorous DQAs	DQAs are sometimes conducted but results are not utilized to improve the system. Capacity of staff to conduct DQAs is somewhat adequate	There is adequate capacity and resources for staff to conduct, DQAs are routinely conducted, but results are not utilized to improve the system.	Systematic data quality audits are well conducted, and used to continuously improve information systems (e.g., identifying and reducing unnecessary reporting burdens, simplifying processes, and/ or utilizing ICT to strengthen processes)
Data Management	There is little or no effort to gather data outside the mainstream HMIS system. Health data exists in many silos	There are efforts to coordinate and integrate data from other sub systems, but such efforts lack form and structure. As a result the sub systems are uncorperative	Data is coordinated and integrated from across some information sub-systems.	Data is routinely coordinated and integrated from across all the different information sub-systems e.g vertical programs

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	**Developing**	**Consolidating**	**Resilient**
	0	1	2	3	4
SERVICE DELIVERY				
Managing Continuum of Care	Essential services are insufficient, and a reliable referral system is lacking,	Essential services are provided to segments of the population. A referral system is established and well maintained, yet it has inadequacies	Essential services are fully provided (to all) in a manner that is patient centered. A referral system is established and well maintained, but communities are not fully engaged in service provision.	Essential services are fully provided (to all) in a manner that is patient centered. A referral system is established and well maintained, and communities and NGOs are fully engaged in service provision.
Managing Service Quality	Clinical quality and patient satisfaction is not monitored. Protocols are inadequate and not monitored for adherence.	Clinical quality and patient satisfaction is inconsistently monitored. The available protocols are sometimes monitored for adherence.	Clinical quality and patient satisfaction is regularly monitored. Service protocols are adequate and adhered to a level that is satisfactory.	Clinical quality and patient satisfaction is frequently monitored. Protocols are adequate and fully adhered to.
Access and Coverage	Barriers to access, especially for poor and marginalized populations are not well understood, nor are they factored in planning service delivery.	Communities are sometimes made aware of specific services and are encouraged to utilize health services. Barriers to access, especially for poor and marginalized populations are well understood, though it is not clear if they factored in planning service delivery.	Communities are often made aware of specific services and are encouraged to utilize health services. Barriers to access, especially for poor and marginalized populations are well understood, and factored in planning service delivery.	Communities are always made aware of all services and are encouraged to utilize health services. Barriers to access, especially for poor and marginalized populations are well understood, and factored in planning service delivery. Cear mechanism for community engagement exists.

Component	CRITERIA FOR EACH PROGRESSIVE STAGE			
	Beginning	Developing	Consolidating	Resilient
	0	1	2	3	4
Public Private Partnerships	Public-private partnerships are not well defined. The Ministry is yet to forge formal partnerships with the private sector	PPPs in health care are beginning to form, there support to health is ad hoc and cannot be quantified. NGOs are engaged in the delivery of health services	Public-private partnerships are established, but information is not gathered on the extent of their contribution. NGOs are engaged in the delivery of health services	NGOs are fully engaged in the delivery of health services. Public-private partnerships are well established to support and deliver services

7.3 Workshop Programmes

CONSENSUS WORKSHOP PROGRAMME			
21st September			
Workshop Objectives			
1. To present the major findings of the Bosaso District HSSD and the proposed recommendations			
2. To get feedback from the stakeholders on the accuracy of the findings and make additional recommendations 3. To understand the health system of Bosaso District so as to empower informed participation in the design of the programming phase			
TIME	**SESSION**	**HIGHLIGHTS**	**FACILITATOR**
8.30am	**Registration**		*Steering Committee*
9.00am - 9.15am	**Opening and Welcome Remarks**	Welcoming and appreciation of all participants Understanding of purpose of Bosaso District HSSD and its contribution to the health sector in Puntland	Abdirizak Hasan Isse *MoH Director of Planning*
9.15am - 9.45am	**Overview of the Bosaso District HSSD**	Background on when HSSD was conducted and its coverage	Johro Muse

	-- Methodology & Approach	How the HSSD was designed including different steps and the formation of the Steering Committee Who it targeted in the KIIs, FGDs, health user questionnaires Role of different stakeholders in action planning in the next programming phase	*MoH Regional PHC*
9.45am - 10.45am	**HSSD Findings**	Understanding of benchmarks utilised in the HSSD Presenting results from the primary and secondary data collection and highlighting preliminary conclusions	John Ndiritu *SDS Consulting*
10.45am - 11.15am	**Health Break**		
11.15am - 12.15pm	**Group Discussions**	Multi-stakeholder groups to verify the accuracy of the findings as per the different building blocks Consolidate the reviews and comments	Abdirisaq Cartan – *MoH Regional HMIS*
12.15pm - 1.30pm	**Prayers and Lunch**		
1.30pm - 2.00pm	**Group Feedback/ Presentations**	Feedback sessions on HSSD findings from the group work	Rayhab Wangari - *SDS Consulting*
2.00pm - 2.30pm	**HSSD Conclusions and Recommendations**	Presenting recommendations for strengthening the Bosaso District health system	John Ndiritu - *SDS Consulting*
2.30pm - 3.30pm	**Plenary Discussions**	Consensus building on the recommendations Multi-stakeholder understanding of the way forward	Abdirisaq Cartan - *MoH Regional HMIS*
3.30pm - 3.45pm	**Wrap up**	Summary of the workshop outputs Defining the next steps	Idiris Mohamed - *MoH MRH Manager* Rayhab Wangari - *SDS Consulting*
3.45pm - 4.00pm	**Closing Remarks and Vote of Thanks**	Vote of thanks	Said Waraabe - *Regional Health Officer*

PROGRAMMING WORKSHOP PROGRAMME

22nd and 24th September

Workshop Objectives

1. To benchmark the outcomes of the Bosaso District HSSD
2. To jointly identify and prioritise the health needs of the District
3. To build synergies of all partners in strengthening the health system of Bosaso District
4. To formulate a joint programming strategy that serves as a blueprint for Bosaso District

DAY ONE		
TIME	**SESSION**	**HIGHLIGHTS**
8.30am - 9.00am	Registration	
9.00am - 9.15am	Opening and Welcome Remarks	
9.15am - 10.00am	Summary of the Diagnosis Outcomes	Presentation of the summary of the HSSD process and outcomes
10.00am - 12.00pm	SWOT Analysis	Group work to highlight the strengths, weaknesses, opportunities and threats of the building blocks of the Bosaso District health system
12.00pm - 1.30pm	Prayers and Lunch	
1.30pm - 2.30pm	Plenary - Group Feedback	Group presentations
2.30pm - 4.00pm	Scorecard	Group work to critically reflect and score the indicators of strengthening the Bosaso District health system
DAY TWO		
9.00am - 9.15am	Recap of Day 1	
9.15am - 10.15am	Plenary - Group Feedback	Group presentations
10.15am - 12.00pm	Programming Prioritisation	Plenary session to fill the prioritisation quadrant and pair-wise ranking
12.00pm - 1.30pm	Prayers and Lunch	
1.30pm - 3.00pm	Programme Logframe with 3Ws	Provide goal and outcomes to promote a synergic approach amongst all stakeholders

7.5 List of Respondents

A. INTERVIEWEES

NAME	ORGANISATION
Group 1: Key Informant Interviews and In-Depth Interviews	
Dr. Abdinasir Osman Isse	Ministry of Health
Dr. *Abdirizak Hassan*	Ministry of Health
Abdirizak Abshir Hersi	Ministry of Health
Idris Mohamed	Ministry of Health
Said Mohamed Warabe	Ministry of Health
Johro Muse Elmi	Ministry of Health
Abdirisak Cartan	Ministry of Health
Said Farah Bayr	Ministry of Health
Mohamed Farah	Ministry of Health
Ayaan Nuwr Muuse	Ministry of Women
Buruuj Ali Salad	Bosaso Municipality
Jihan Salad	UNFPA
Said Mohamed	WHO
Hashi Hersi Omar	UNICEF
Eng. *Abdirashid Yusuf*	University of Health Science, Bosaso
Dr.	Bosaso General Hospital
Abdullahi Bashir	Save the Children
XX	Save the Children
Baxtan Hassan Mohamed	World Vision
Mohamud Issa Farah	GRT
Mahad Umar	ISDP
Farhia Abduluwahab	ISDP
Omar Ali	ISDP
Muna Ali Aden	BADBAADO
Group 2: Focus Group Discussions	
Maryama Maxamed Axmed	Student
Hawa Jama Abdirahman	Student

NAME	ORGANISATION
Haawa Mohamed Said	Student
Shauris Mahad Bulxan	MOWDAFA
Faadume Oumar Drahman	Student
Afaan Newr M	MOWDAFA
Farxiya Maxamed Said	Local Government
Faadumo Omar Salad	Student
Sumayo Jahmal Mahamd	MOWDAFA
Najmu Mohamed Ahmed	Student
Osman Ashir Osman	Community Leader
Mustafe Adan	Religious Leader
Sulumon Hassan Maxamed	Community Leader
Mohamud Abdi Ahmed	Student
Osman Jama Ahmed	Student
Abdirisaaq Cilabi	Religious Leader
Aisho Mohamoud Omar	Community Health Worker
Deefo Mohamed Abdikarin	Community Health Worker
Fartun Abdiqadir Mohamed	Community Health Worker
Ubah Omar Haji	Community Health Worker
Jamito Mustaf Aweyle	Traditional Birth Attendant
Hawo Nuur Mire	Traditional Birth Attendant
Batulo Ahmed Ayuub	Traditional Birth Attendant
Halimo Khalif Yusuf	Traditional Birth Attendant
Fartuun Nuur Hasan	Community Health Worker
Abdi Maheel Asman	Community Health Worker
Sharmake Husein	Youth
Mahamed Abdikadir Said	Youth
Dayax Abdullahi	Youth
Mahamed Abdullahi	Youth
Abdrisaaq Mohamed	Youth
Mohamoud Ahmed	Youth

NAME	ORGANISATION
Kamal Mire Abdi	Youth

B. WORKSHOPS PARTICIPANTS

NAME	ORGANISATION
Hashi Abdi Guled	Bydo
Elmi Omar Haji	East African University
Abdifatah Ahmed Ali	East African University
Mohamed Said Yusuf	Save the Children
Abdullahi Mohamed Warsame	Save the Children
Said Farah Bayr	MoH
Mohamed Mahud Abdi	MoH
Mohamed Ali Kobra	MoH
Mohamed Abdinasir Sirad	TASS
Fadumo Abshir Geire	MdM
Lathan Billow Abdullahi	MdM
Mohamud Issa Farah	GRT
Mahad Omar Hersi	ISDP
Abdulkadir Abdullahi	University of Bosaso
Mohamud Said Isse	University of Bosaso
Ayaan Nuur Muse	MOWADAFA
Shamis Mahad	MOWDAFA
Khadija Mo'alim Mohamed	MOWDAFA
Abdullah Jiindhey	University of Health Science
Abdulfetah Jibril	University of Health Science
Buruuj Ali Salad	Bosaso Municipality
Muna Ali Aden	BadBaado
Halima Abdizaq Isse	Nurse – MCH facility
Sacdaa Ahmed Ali	WAWA
Sahra Jama Farah	Somalia Red Crescent Society
Faadumo Yusuf Asman	MCH facility
Abdinasir H. Yusuf	Save the Children
Mohamed Bashir	MoH
Idris Abdulahi Mohamed	MoH
Mohamed Hersi	MoH
Mohamud Abdullahi	World Food Programme
Farhia Abdiwahab	ISDP
Abdirisaq Mohamed Cartan	MoH
Mohamed Farah Ali	MoH
Johro Muse Elmi	MoH
Said Warabe	MoH
Rayhab Wangari	SDS Consulting
John Ndiritu	SDS Consulting
Omondi Otieno	SDS Consulting

C. DATA ENUMERATORS

NAME	GENDER
Abdirahman Mohamed Hanshi	Male
Abdisalaam Hamud Abokar	Male
Abdawahab Abdullahi Abdirahman	Male
Fatima Ali Mohamed	Female
Kaltuun Hassan Ali	Female

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